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PSYCHOANALYSIS AND THE SUPERNATURAL: TWO ESSAYS

MAGIC IN CONTEMPORARY LIFE AND IN PSYCHOANALYSIS — Arnold W. Wilson

A PSYCHOANALYTIC INTERPRETATION OF SHAMANISM — Robert F. Kraus

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BOOK REVIEWS by Richard E. Felder, Ernest W. Ferneau, Jr., Herbert J. Freudenberger, Charles K. Hofling, Marie Coleman Nelson, Stephen A. Reid, Hattie R. Rosenthal, Adolf G. Woltmann and Dorothy F. Zeligs

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MAGIC IN CONTEMPORARY LIFE AND IN PSYCHOANALYSIS

Arnold W. Wilson

In 1925, Malinowski wrote:

> Looking from far and above from our high places of safety in the developed civilization, it is easy to see all the crudity and irrelevance of magic, but without its power and guidance early man could not have mastered his practical difficulties as he has done nor could man have advanced to the higher stages of civilization.[23]

This concept of Western science replacing primitive magic has been echoed by historians, both general medical and psychiatric,[1,16,38] and is the central theme of our education. Several years before Malinowski's statement, however, Freud[10] and Ferenczi[7] had already pointed out that magic persists in our culture in the infant, in psychopathology, in art and in fairy tales.

My observations are that magic is very much alive in all the areas of our scientific, industrialized culture, including our own field of psychoanalysis. Further, there seems to be evidence of an increased interest in magic among some segments of educated youth; a reversal of the historical trend from science back to magic. This paper attempts to point out the existence of magic in our world, both social and psychoanalytic, and offer some possible explanations for the revival of interest in magic recently. Frazer's conception of magic, religion and science serves well to establish our definitions: in magic, man depends on his own supernatural power to cope with the environment; in religion, man ceases to rely on his own power and, instead, turns to an unseen power outside himself; in science, man postulates an order to natural phenomena and he attempts, by

* Presented at a meeting of the Southern California Psychoanalytic Society, December 10, 1969.

patient, careful study of the order in nature, to understand and cope.[8]

Interrelationships between magic and science exist, and can be complex. For instance, in pharmacotherapy, not only can science be magic in disguise, but magic is sometimes science in disguise. IBM machines programmed to produce a personal horoscope (more and more in evidence recently) is an example of science in the service of magic. Television commercials provide ample examples of magic in the service of industry, particularly the detergent industry: Ajax, the Magical White Knight; Bold, a Magical Giant in your washer, etc. A wedding of science and magic is seen in the field of organ transplants. Lunde, studying the families of donors of hearts, reported "an intense involvement with the recipient of their family member's heart, and they seemed to experience a delayed grief reaction when the recipient died."[22] An example of magical transmigration of the soul, as well as transplantation of the organ. The unusual success in recent years of several movies and television programs that have magic as their central theme is noteworthy. The continual growth of Las Vegas and other gambling centers attests to the potent force of the magical feeling of luck. These are just a few examples of magic in our society and are by no means exhaustive.

In the last year, articles and advertisements pertaining to various aspects of magic have been appearing with increasing frequency in the lay press.[2,9,13,19,21,24,28,33,34,35] These articles motivated me to some investigations of my own, to half-a-dozen book stores, three witchcraft meetings, five interviews with young people recently interested in witchcraft and finally, a visit to a store operated by a Satanic Master with a sign in the window "Witchcraft Items to the Trade." At the bookstores, half selected because of their specialty in the occult and half at random, I was able to find scores of volumes on various aspects of magic. The best sellers seem to be the "how to" books, on occult phenomena, on astrology, tarot card reading, charms and talismans, and autobiographical "proof" books.[3,4,5,18,20,27,31,32] The booksellers, without exception, volunteered their observations that interest in books on magic, particularly among young adults, had dramatically increased in the past three years. I then attended two lectures on witchcraft at the Experimental College at the University of California at Los Angeles, and one lecture in a nonacademic setting. The audiences were young, alert, intelligent, and with rare exceptions, not particularly bizarre in appearance. In each instance,

the meeting room was full, about fifty people at the first two, and about thirty at the third. True believers seemed to comprise the majority. The remainder were divided mainly between those seeking to be convinced and a small number of what I took to be anthropology and sociology students, taking notes. All the speakers had a mildly paranoid attitude toward nonbelievers, scientists and some specific other witches. The main theme centered on power, how witches acquire it, how to use it for good or evil, and how to ward off the power of others. The power sought was aggressive, mainly creative and to a lesser degree destructive and protective from the destructive aggression of others. Sexual power as a goal was not mentioned, but there was a good deal of interest in how to get, keep and control a love object. The wish for power, intrapsychic, interpersonal, and environmental, was central.

At one of these meetings, I learned of a store that specialized in equipment for witches and contacted the owner, Mr. M. We met twice. He was a pleasant, intelligent, responsive man in his middle thirties, quite willing to talk about his work, and he had no objection to my taping the interviews. At the beginning, Mr. M. presented himself as an unlicensed fellow psychotherapist, whose main function was to be aware of the needs and wishes of his clients, conscious or unconscious, and to reassure them that their wishes would be realized (essentially the same concept as Freud's as to the method of the functioning of the successful fortune teller).[11] As our interview proceeded, however, he talked more and more of his unusual talents, providing much anecdotal evidence of his supernatural powers. Although he had been interested in mysticism and impressed with his unusual talents since his adolescence, he had only been working professionally for the past three years, pressured by friends.

He estimated during this three-year period he has seen two to three thousand clients, more than half in the last six months (prior to July 1969). He said his clients range from those who want a horoscope or a book on occultism to those who want to study witchcraft, who buy books, equipment, spells and rituals, those who want help in joining or forming a coven, and those who are already practicing witches who wish to buy more complex equipment and rare books, and finally, those witches who wish to use his services as a consultant. Although there is marked diversity in his clientele as to age, intellect, education and socioeconomic status, recently, he

states, the majority are young adults, more girls than boys, eighteen to twenty-five, who are attending and functioning well at high school or college, most living at their parents' home, and frequently at the end of an unsuccessful love relationship. Most have some, but relatively little, sexual experience. Rarely, if ever, are they student militants. Some are quite involved with drugs, but tend to stop spontaneously, shortly after they turn to witchcraft. This picture of the majority of his clients coincides with my own observations both at the witchcraft lectures and in individual interviews.

He estimated that there are "several thousand practicing witches" in Southern California, of all persuasions, including ancient English and Italian witch cults, Jamaican and Haitian Obeah, African and Louisiana Voodoo and Mexican Curanderismo. These have not enjoyed an increased demand recently but have served as psychotherapists to poor and uneducated minority groups, the methods and practitioners having accompanied these minorities in their migration from their parent culture. The recent increase in interest comes mainly from the middle and upper-middle-class youth.

Even taking into account the possibility that Mr. M. was inflating his statistics a bit, trying to fulfill *my* wishes, still it was a most remarkable interview, for 1969, even in Los Angeles.

Freud, in his paper "Psychoanalysis and Telepathy," comments on an increased interest in occult phenomena after the First World War and speculates on the reasons as follows: "It is a part expression of the loss of value, by which everything has been affected since the world catastrophe of the Great War, a part of the tentative approach to the great revolution towards which we are heading, and of whose extent we can form no estimates. . . ."[11] Interestingly, his explanation was more sociologic than psychoanalytic. Let's temporarily leave this question of why the increased interest in magic and see if some clinical and theoretical data will offer any clarity.

MAGIC AND THE PATIENT

People in the world of magic that I have just visited are not usually seen by the psychoanalyst. Instead, belief in magic, wish for magic, and fear of magic, usually are unconscious and emerge in the course of clinical work. The following are four clinical examples which demonstrate, in different ways, how magic played a significant role in the intrapsychic process, as well as in the treatment.

Case 1: Fear of One's Own Malevolent Magical Power

A thirty-eight-year-old married man sought analysis because of chronic anxiety, feelings of inferiority and difficulties in interpersonal relations. The anlysis extended over a ten-year period with two prolonged interruptions, resulting in approximately seven years of analytic work. Through the first eight years of treatment, he was tormented by anticipation of failure in his vocation, despite all evidence to the contrary. He was the only child of a narcissistic, infantile mother and a highly successful businessman, whose work took him away from the home for prolonged periods of time. His father died suddenly of a heart attack when the patient was eleven. He related in analysis (as elsewhere in his life) by being ingratiating, charming and seductive, and when he sensed a positive response he would withdraw, always giving control precedence over intimacy. The two interruptions in his treatment coincided with points where there was a growing feeling of closeness and trust towards the analyst.

In the final portion of the analysis, he came to an awareness that his feelings of inferiority and his need to maintain distance were really mechanisms designed to protect those he loved from his own unconscious feelings of omnipotent magical malevolent power. He worked through his terror of his own unconscious power, recovered the memory that his own unconscious fantasies had killed the father, whom he also loved. He came to appreciate that his obsessional fear of failure and ineffectiveness served to keep his feelings of magical, malevolent power out of awareness. He was able to work through his ambivalence, his fear of destroying a loved one, and to give up many of the defenses against this fear which caused such pain and failure in his human relations. Although the basic issue could be understood as Oedipal, interpretation of Oedipal rivalry and Oedipal guilt met with responses of ingratiating interest and intellectual pseudoacceptance, but when the concept of fear of malevolent magical power was clearly introduced, real anxiety emerged and this became the pivotal point for working through, and ultimate resolution.

Case 2: The Search for the Benevolent Magician

A thirty-nine-year-old divorced woman came to treatment because she felt she had not realized her creative potential as a commercial artist and dress designer. Her other complaint was her difficulty in

maintaining a love relationship. She lived in a hippie neighborhood, used marijuana and, occasionally, LSD, and dressed in the extreme "hippie" fashion. She had considerable difficulty with her two teenage children from a short-lived marriage, because of her inability to feel like and act the responsible parent. For years she had maintained a serious interest in astrology and maintained her private astrologer on a yearly retainer. She was an ardent student of yoga and a food faddist. Her boyfriends were all ten to fifteen years her junior, to whom she would relate ambivalently, enjoying their sexual desire for her, and resenting their immaturity. She was the only child of a short-lived marriage. After the father deserted when she was two, the patient lived with her mother and a parade of undependable men. The mother tried to depend on the patient from puberty on and was resentful and critical that the patient could not adequately serve her needs. The patient's obvious ego defects led me to recommend psychotherapy on a weekly basis. When I was able to achieve some comfort in the presence of her unusual appearance and colorful idiom, I discovered she was a highly sensitive, intuitive, creative woman, tormented by her negative introjected object, the condemning mother, and consciously feeling little self-esteem. My early confrontation that she expected me to have magical power, she not only readily acknowledged but said she felt that I was withholding because I didn't like her enough, and her hope was to become sufficiently interesting to me that I would be more kindly disposed and put my magical power at her disposal. During the first six months of treatment, as I made efforts to understand her and made little other than an occasional supportive comment, she reported that she seemed to feel a little less worthless. Three months after starting treatment, she was offered a job designing clothes for an unimportant low budget movie. However, to everyone's surprise, the picture received wide attention and her clothes set a style trend. At the end of the year, she was a well-known designer with more offers for work than she could fulfill. We continued our weekly appointments. A few months later she phoned, and with considerable agitation asked for an emergency appointment. When she arrived, she reported that her astrologer had predicted that the next month would bring violent upheavals in her personal and professional life and she wanted to see me daily to protect her during this precarious period. She had become convinced I was the powerful, benevolent

magician who had changed her life and now could even reverse the destiny of the stars. Although *we* would say supportive therapy served to augment her ego functions and dilute her punitive mother introject, permitting her to operate at a more efficient level where her creative talents could be realized, her conviction that I had magical power remained firm. When we agreed to terminate at the end of two years, it was very important for her to know that I would be available to her whenever she needed me. This case raises the question: how often is the unanalyzed belief in magic the main issue in transference cures?

Case 3: The Fear of the Analyst's Malevolent Power

A woman patient became anxious in treatment when she started to perceive me as effective. She was fearful that if I was able to understand her better than she did herself, then I was also a potential threat, capable of controlling and manipulating her with my magical power for my advantage. Her parents were divorced when she was three; shortly thereafter she developed a chronic illness that kept her bed-ridden until puberty. The mother devoted her life to the nursing of the patient. There was an apparently comfortable symbiosis between mother and daughter until adolescence, when the mother could not tolerate the double blow of the patient's medical recovery and her move towards other objects, and a stormy struggle continued until the patient left home in late adolescence. The preadolescent symbiosis was perceived by the patient as herself precariously occupying the omnipotent role in relation to the devoted servant mother. When my effective intrusions challenged her omnipotence, she was threatened.

Case 4: Conceptualizing Affect In a Magical Idiom

A thirty-two-year-old woman in the terminal phase of a relatively uncomplicated analysis felt reluctant to agree on a termination date because, she felt, "You are my magic amulet. I'm afraid if I give you up I'll lose all my gains." Her father's absence during the Second World War (her fourth to seventh years), the suddenness of his departure, together with a confusing explanation, resulted in this event becoming a pivotal point of her neurosis, as well as the analytic work. Interpretation of her fear that her departure from treatment would be perceived by me as a hostile rejection and she would then

feel the guilt of causing me to suffer what she had suffered with her father's departure, was sufficient to permit her to comfortably give up her amulet. This conceptualization of the analyst as an inanimate amulet contains the same dynamics as the relationship between the believer and his magic amulet. The possession of the amulet serves to neutralize projected hostility and guilt.

These cases suggest at least three generalizations: the more narcissism and unrepressed omnipotence, the more belief in magic; the more ego defect, the more the belief is conscious; and the more troubled the pre-Oedipal experience, the more likely the adult belief in magic.

OMNIPOTENCE AND MAGIC

Freud, Ferenczi and Roheim pointed out the crucial connection between omnipotence of thought and magic.[7,12,29]

The fate of omnipotence is very well summarized by Pumpian-Mindlin[26] as follows: Infantile omnipotence represents the primal state before any recognition of objects. Infantile frustration forces recognition of the existence of external objects and represents the beginning of ego formation. As the infant recognizes individuals outside himself, he must acknowledge his helplessness and now attributes omnipotence to the external object. Since language develops during this period, omnipotent feelings become linked with verbal concepts and language represents the dual attempt to acquire the real power of the parents as well as to regain omnipotence. At this point, if the struggle for power is too fierce, the child may be fixated at this level of omnipotence of thought and the magic of words becomes dominant in the subsequent character formation. If, on the other hand, the child acknowledges the parents' power and his own powerlessness, his omnipotent fantasies become repressed and the struggle for narcissistic gratification results finally in the internalization of the conflict and establishment of the superego. Through the Oedipal and latency periods, the ego struggles towards more reality orientation, but omnipotent fantasies lurk in the background in the form of play and fairy tales. At puberty, infantile omnipotence reappears. In later adolescence, identification with the parental object results again in repression of the infantile omnipotence.

My cases, despite individual variations, demonstrate the failure of the child to acknowledge parental power with the subsequent in-

complete repression of omnipotent fantasies. Does the absent father in all four cases simply mean less adult power to the child or does the father's absence lead to a regressive narcissistic defense against the more intense, mother-child symbiosis? In either case, my clinical material, together with Pumpian-Mindlin's theoretical concepts, leads us to one possible explanation for the increased interest in magic in today's youth. During the time of their pre-Oedipal year, during and after World War II, family disruption, absent fathers, and maternal anxiety about the uncertain future were not only common, but the rule. In addition, the fashion in child rearing, by the educated in particular, tended more to gratification and permissiveness, and less to limit setting and control. Is it possible this infantile experience left a large segment of today's youth with faulty repression of omnipotence and a readiness to turn to magic as young adults as a means of mastering their world?

EFFECTIVENESS AND MAGIC

Ego psychology presents a somewhat different viewpoint of the infantile experience. Rather than seeing the ego as growing totally out of the early struggle for omnipotent power, Hartmann advances the concept of the primary autonomy of ego apparatuses.[17] Where Ferenczi describes the mother's response to the helpless infant's cry as reviving the infant's feeling of omnipotence,[7] Robert W. White, examining the same example of the crying infant, says, "The power of the infant's cry to summon the mother might be taken as a very early arena for the testing and growth of inter-personal competence."[35] Salzman,[30] in describing the obsessive personality, shifts his emphasis from Freud's instinct theory to the fear of weakness and inadequacy. With inadequacy, he states, there are two possible reactions: one is to find someone to depend on, the other is to try to force one's self into feeling stronger than one actually does. Salzman rejects Freud's view that feelings of omnipotence characterize the infant, from whence they return in neurosis. Instead he holds that the infant's feelings of insecurity lead, with support from adults, to comfortable feelings of self-worth. It would seem to follow that from the viewpoint of ego psychology, magic would be expected to appear when realistic effectiveness falters. That is to say, an ego defect relative to the demands of the environment, rather than our usual definition of ego defect, namely a developmental impairment characteristic of

adult psychoses and borderline states. For example, the great interest shown by prepuberty boys in performing magic tricks usually ceases abruptly with the onset of puberty. The prepuberty ego has a temporary relative defect in coping with hostile impulses, and performing magic tricks temporarily fills the defect. This leads us to a second possible explanation for youth's interest in magic: Does a significant portion of youth find science disappointing as a method of mastering the world? "Knowledge is power" is no longer an effective concept in perceiving and adapting to their world, and they are not impressed with its efficiency in their parents' world, either. Further, they feel science not only fails them as a means of coping, but some applications of science become the greatest threat to their future existence.

Let's now consider the anthropologic view of magic, as presented by Wittkower and Weidman.[37] For the anthropologist, magic is in the service of maturation, adaptation and integration, is learned in childhood, and is not necessarily associated with ego defect. They point out that this concept is arrived at mainly from studies of so-called primitive cultures.

There are, then, basically three different concepts of magic. The psychoanalyst understands magic as a regressively omnipotent phenomenon in the presence of an ego defect; from the viewpoint of instinct theory, magic is seen as a regressive method of discharging aggression and sexuality and reducing anxiety; from the viewpoint of ego psychology, magic is a regressive method of achieving a feeling of effectiveness and power. The anthropologist sees magic as a learned, social mode, facilitating maturation, adaptation and integration and not necessarily associated with psychopathology. The anthropologist studies primitive culture where magic is successfully adaptive within that culture and scientific information is lacking. The psychoanalyst finds ego defect and unresolved omnipotence in patients who turn to magic, which is maladaptive within their culture. The psychoanalyst's goal is to facilitate development of more effective ego function, resolution of omnipotence, and discovery of more effective and realistic methods of coping. That segment of our youth that has turned to magic, it seems to me, needs to be studied by combined psychoanalytic and sociological methods to discover what are the important determining factors—disillusionment with science, unresolved infantile omnipotence, or both, or other possibilities not

considered in this paper. And to what degree is their behavior adaptive or maladaptive?

MAGIC AND THE PSYCHOANALYST

Born out of the magic of hypnosis, developed through instinct theory, and then ego psychology, psychoanalysis has achieved its scientific maturity. However, it is relatively easy to find contemporary evidence of our magical heritage.

Although most clinicians perceive psychoanalysis as a body of scientific knowledge, some, particularly when discussing specific points of theory or technique, sound more like the faithful in a magical cult than like scientists. As individual clinical experience reaffirms the validity of theory, there seems to be a subtle and hardly perceptible tendency to move from a scientific to a magical cult-like orientation.

It has been frequently pointed out that the clinical successes of the giants in psychoanalysis may be as much a function of the magical aura that envelops them, as their specific theoretical orientation or innovative techniques. Dreams, so important to the psychoanalyst, are all examples of magic; the psychoanalyst has developed his own scientific system to utilize the magical therapeutic force within the dream. The psychoanalyst, in his training and in his work, is under pressure to possess magical power from two sides, his own unconscious and his patient.

Phyllis Greenacre,[14] in her series of papers dealing with problems of selection and training of psychoanalytic candidates, states that despite careful selection, related particularly to problems with narcissism, the process of being accepted for training arouses or increases narcissism and competition. "The narcissistic aura of being an analyst sometimes unfortunately gains a *magical* quality which may be a handicap in personal analysis."[15]

In seminars, there is a further stimulation in competitiveness, exhibitionism and narcissism. It would seem that the structure of training carries with it an everpresent hazard, where maturation may not be served, but rather, in the climate of increased narcissism and competitiveness, the student is tempted to comply for the ultimate goal of earning the rights to the magical secrets. The opposite—discovering one's own narcissistic strivings for magical power, renouncing them in favor of the discovery of one's realistic powers, hopefully occurs more often than not.

If the candidate survives the hazards of narcissism in training, is he then safe from magic contaminating his scientific identity? Not entirely. There are two further hazards: the patient's expectation and the transference. Malinowski[23] describes the four common elements in magical practices in primitive cultures as follows: (1) the rite, a particular ritualized action, (2) the spell, a particular ritualized verbal incantation, (3) the attitude of the magician, strong affect about his work and conviction of his possession of magical power, and (4) belief in the magical power of the practitioner by the client. Other anthropologists have pointed out, in addition, that the magician is usually a person of influence and prestige in the community and is required to observe certain taboos, such as refraining from eating certain foods or avoiding certain sexual activity.[25] Although the psychoanalyst may feel no identification whatsoever with the primitive magician, the patient so often, consciously or unconsciously, brings to the treatment hope for magic. The ritual of the appointment, the spell of the exact interpretation, the ethical self-denial of gratification by the psychoanalyst, and his unambivalent convictions about the right way to proceed, all tend to reinforce the patient's already existing expectation of magic. There is one structural difference, however, but a crucial one. Whereas the magician arrives for this training convinced of his special powers, the carefully selected psychoanalytic candidate arrives at his training only with an insatiable curiosity about himself and others, with little conviction about his ability to effect changes in others or himself, and acknowledging his own ambivalence, a strong motivation to experiment and learn. Saying the same thing in reverse, the clinician who *is* narcissistically impressed with his inherent intuitive ability and has an unambivalent conviction about the rightness of his particular theory and technique shows no basic difference from the primitive magician. The analyst then, in his daily work, is under continual pressure to accept the identity of magician. Erik Erikson,[6] in discussing juvenile delinquents, presented the concept that the police and the courts often assign a criminal identity to the delinquent and some accept this identity for life. Hopefully, the psychoanalyst's readiness to succumb to such an externally assigned identity is not great, but nevertheless we all must live with this implicit pressure in our daily work.

The final intrusion of magic in the psychoanalytic situation

relates to the transference. Transference is not only determined by key figures in the patient's past life, but also represents certain key times in the childhood of the patient. We would expect then, if there is a predominantly pre-Oedipal ingredient in the transference, that the childhood belief in the magical omnipotence of the adult will also be transferred to the analyst, and require considerable analytic attention.

Finally, is the recent waning interest in psychoanalysis and the increased interest in other theories and techniques in psychiatry scientific progress or possibly, in some instances, an example of turning from science back to magic, similar to what we have seen in the young people who first aroused my interest in this subject?

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A PSYCHOANALYTIC INTERPRETATION OF SHAMANISM

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> *. . . this term refers to persons of both sexes who have mastered spirits, who at their will can introduce these spirits into themselves and use their power over the spirits in their own interests, particularly helping other people, who suffer from the spirits; in such a capacity they may possess a complex of special methods for dealing with the spirits.*[17]

The shaman is one of the most interesting figures in anthropology. The exotic and emotionally charged nature of shamanistic practices and their widespread distribution in primitive cultures of the world have attracted investigators from a variety of disciplines. Examination of the classic summary by Eliade[7a] gives some idea of the large and complex body of literature that has resulted. Interestingly enough, despite all these studies the concept of the shaman has remained an elusive one, about which there is great disparity of opinion. All over the world, the primitive cultures in which the shaman flourished are fast disappearing. For this reason there is urgent need for further study of the problem before the opportunity ceases to exist. This paper will approach the concept of the shaman from a limited and somewhat specialized viewpoint, that of the clinical psychiatrist. Two themes will be developed: first, a model for shamanistic behavior will be defined and will be seen as incorporating and enacting themes of great individual psychological significance and cultural importance; second, it will propose that the shaman is selected for his task on the basis of a rather unique constellation of personality traits which fit him to play a role of central importance in the social organization of his group.

HISTORY AND BACKGROUND

Linguistic studies reveal that the word "shaman" is Russian and is derived from the Tungus saman. There are a variety of corresponding terms in other central and northern Asiatic languages. A possible derivation from the Hindu samana or the Chinese sha men is proposed by those who hypothesize a historical development of shamanism from the Buddhism of China and India. Since the term was first introduced into the anthropological literature by the Russians, who contacted the Tungus in the 17th Century, it has undergone increasing elaboration and extension. At the present time the concept of shamanism includes a range of loosely related phenomena in many parts of the world, especially among Eskimos and American Indian peoples, but there is little agreement as to scope or role. Eliade's survey of pertinent literature reveals the shaman to be characterized as priest, physician, magician, sorcerer, exorcist, political leader, psychotic, and mountebank. Studies have been undertaken within a variety of frames of reference. The shaman has been approached from the standpoint of psychology, a viewpoint which will be developed further below. Sociological studies have emphasized role, structure, and social organization. Numerous ethnological studies have provided valuable descriptive information and have attempted to integrate the concept "shaman" into a variety of different cultural contexts. Students of religion have been particularly interested in shamanism as a unique type of religious experience. Historians have long interested themselves in the development and distribution through time of this complex concept. The widespread distribution of various aspects of shamanistic practice through primitive cultures in different parts of the world has further added to the complexity of the picture. Hultkrantz[10] has proposed a classification of shamanism involving two main types. The first type, general shamanism, is common in many parts of the world and is characterized by considerable variation, but usually low intensity in its forms of expression. The second type, Arctic shamanism, is characterized by more limited distribution and greater uniformity and intensity. Arctic shamanism, as the name would imply, dominates the Eskimo area, parts of the northwest coast and the Arctic areas west of the Bering Strait. He postulates that Arctic shamanism developed upon the foundations of general shamanism and may be defined as an ecologically conditioned special form of the latter. This distinction is a valuable one

because it systematizes the general impression that shamanism, although widespread, is considered by many to be found in its most highly developed form in the circumpolar area, whose historical tradition has contributed to its growth.

THE ANATOMY OF SHAMANISM

In view of the above, it is not surprising that the student of this problem finds it difficult to formulate a concise, detailed definition of shamanism which includes its essential elements. It is, however, essential to the development of the concepts in this paper that this be attempted. To do this, I propose to analyze autobiographical statements of three shamans from different areas of the world, with the objective of enumerating the essential dimensions of this concept from the psychiatric point of view and establishing a "skeletal" definition which will be applicable cross culturally even though hidden by the "flesh" of different cultures.

Kintara, Shaman of Hatibadi

The first autobiographical sketch was collected by Elwin,[7b] who studied shamanism among the Savara, an aboriginal Indian tribe. Reference has been made to theories relevant to the Chinese and Indian historical origins of Siberian shamanism. This autobiographical statement, which deals primarily with initiation into shamanism and the relationship with the tutelary spirit, is probably the oldest of the three historically.

> When I was about twelve years old, a tutelary girl called Jangmai came to see me in a dream and said, "I am pleased with you; I love you; I love you so much that you must marry me." But I refused, and for a whole year she used to come making love to me and trying to win me. But I always rejected her until at last she got angry and sent her dog (a tiger) to bite me. That frightened me and I agreed to marry her. But almost at once another tutelary came and begged me to marry her instead. When the first girl heard about it she said, "I was the first to love you, and I look on you as my husband. Now your heart is on another woman, but I'll not allow it." So I said "no" to this second girl. But the first, in her rage and jealousy, made me mad and drove me out into the jungle and robbed me of my memory. For a whole year she drove me.

Finally the boy's parents called in a shaman from a neighbor-

ing village and the first tutelary spoke through his mouth: "Don't be afraid I'm going to marry him. . . . I will help the boy in all his troubles." The father was satisfied and arranged the marriage. Five years later Kintara married a woman of his village. After the wedding, Jangmai, the tutelary, addressed Dasuni, the bride, in these words through their husband's mouth: "Now you are going to live with my husband. You will fetch his water, husk his rice, cook his food; you will do everything, I can do nothing. I must live below, all I can do is to help when trouble comes. Tell me, will you honor me or no, or are you going to quarrel with me?" Dasuni answered, "Why should I quarrel with you? You are god-wife and I will give you everything you need. You and I will live together as sisters." Then she said to me, "Look! Keep this woman as you have kept me. Do not beat her. Do not abuse her." So saying, she went away. Kintara had a son and three daughters by his earthly wife and by his tutelary, a son and two daughters, who live in the Under World. When the boy was born, the tutelary, Kintara continued, "Brought him to me and told me his name; she put him in my lap and asked me to make arrangements for his food. When I said I would, she took him down again to the UnderWorld. I sacrificed a goat for the child and dedicated a pot."

The Goldi Shaman

Sternberg[7b,18] collected the following autobiographical account of a Goldi shaman. (The Golds inhabit the Amur River region.) This account also describes the initiatory phenomena and goes into some detail concerning the distinction between the tutelary spirit and the secondary or helping spirits who are subordinate to it.

> The old folks say that some generations back there were three great shamans of my gens. No shamans were known amongst my nearest forefathers. My father and mother enjoyed perfect health. I am now forty years old. I am married, but have no children. Up to the age of twenty I was quite well. Then I felt ill, my whole body ailed me. I had bad headaches. Shamans tried to cure me but it was all of no avail. When I began shamaning myself, I got better and better. It is now ten years that I have been a shaman, at first I used to practice for myself only, and it is three years ago only that I took to curing other people. A shaman's practice is very, very fatiguing. . . . Once I was asleep on my sickbed, when a spirit approached me. It was a very beautiful woman.

Her figure was very slight, she was no more than half an arshin (seventy-one cm.) tall. Her face and attire were quite as those of one of our Gold women. Her hair fell down to her shoulders in short black tresses. Other shamans say that they have had the vision of a woman with one half of her face black and the other half red. She said: "I am the Ayami of your ancestors, the shamans. I taught them shamaning. Now I am going to teach you. The old shamans have died off and there is no one to heal people. You are to become a shaman." Next she said, "I love you, I have no husband now, you will be my husband and I shall be a wife unto you. I shall give you assistant spirits. You are to feel with their aid and I shall teach and help you myself. Food will come to us from the people."

I felt dismayed and tried to resist. Then she said: "If you will not obey me, so much the worse for you. I shall kill you."

She has been coming to me ever since, and I sleep with her as with my own wife, but we have no children. She lives quite by herself without any relatives, on a mountain, but she often changes her abode. Sometimes she comes under the aspect of an old woman, and then sometimes that of a wolf, so she is terrible to look at. Sometimes she comes as a winged tiger. I am mounted and she takes me to show me different countries. I have seen mountains, where only old men and women live, and villages, where you see nothing but young people, men and women; they look like Gold and speak Goldish, sometimes these people are turned into tigers.

Now my Ayami does not come to me as frequently as before. Formerly, when teaching me, she used to come every night. She has given me three assistants—the Jarga (panther), the Doonto (bear), and the Amba (tiger). They come to me in my dreams and appear whenever I summon them while shamaning. If one of them refuses to come, the Ayami makes them obey. But, they say, there are some who do not obey even the Ayami. When I am shamaning, the Ayami and the assistant spirits are possessing me: whether big or small they penetrate me, as smoke or vapor would. When the Ayami is within me it is she who speaks through my mouth and does everything herself. When I am eating the "sukdu" (the offerings) and drinking pig's blood (the blood of pigs is drunk by shamans alone, lay people are forbidden to touch it), it is not I who eat and drink, it is my Ayami alone.

Pegliruk, the Eskimo

Giddings[9] gathered this account during field work at Shungnak on the Kobuk River, Alaska, in 1940. Pegliruk, whose English name was Charlie Custer, was at that time seventy years old and was the last old person of the Shungnak region to have grown to young man-

hood before the coming of the Europeans. Giddings describes him as having a remarkably clear mind and a keen insight into the workings of his society. His store of knowledge about his environment was very great. Pegliruk was a man of dignity, who was accorded great respect by his neighbors. He describes himself as "Able to do some spirit things" and reminisces about several great Angatkoks whose seances he had attended in his youth.

I am what they call Enyeoloon. This Enyeoloon can cure headache and things like that. He has no spirits—just rubs the body, sets broken bones, pulls teeth, and fixes people up the best he can. I myself can do some spirit things, but only when I am alone. I tried a trick one time. I cooked a hot cake by myself in the tent and cut it in two, laid it on the floor, the halves against each other, and sang a song I had for that way of doing. I waited awhile and then looked. Half of the hot cake was healed up, but the other half was not. Maybe that song didn't work because white man's flour spoil the working of the song. . . . When a man wants to be Angatkok he has to dream. When he has these dreams he begins to vomit blood. Then he goes out in the woods alone, where he hears things he cannot see. After that, when going out in the woods he meets people like human beings, but these are animals really. Then one day he takes off all his clothes and goes out and travels for a long time. He doesn't know he is doing that—the Tunerak (spirit) makes him do it. After that he gets to be a better and better Angatkok. Next he makes a drum and uses it. Then he is ready to do tricks—he is Angatkok . . .

Keseruk, I remember best of all because I used to help him get ready to do things. Keseruk would tell the people to make two arrows for him—"Make good arrows with deer horn tips"—and to make a strong birch bow, nearly an arm's span long and back it with sinew. . . . Keseruk used stone lamp light at first. He would say, "Little persons coming now—both have bow and arrow." Nobody can see them but Keseruk, because Angatkok has a mind that goes out of the body while another "devil" mind comes in. When he says those little persons have come, some people put Keseruk on top of a caribou skin, tie his feet together at the ankles, tie his hands tight behind him, tie his knees and then pull the rope around his neck and under his knees and tie it. He can't move. Now they put the bow on his left side and arrows on his right. They take charcoal and rub a wide black mark across both eyes. But Keseruk couldn't move, these people took drums and started to sing. Somebody is ready to put out the lamp. But they never put out the light right away. Keseruk says, "When

the little persons come they will take my body and use it—when they start to speak through me, you must put the lamp out." Soon everybody shuts his eyes and sings and the lamp goes out. Then they can hear Keseruk clapping his hands, and patting his feet on the floor, saying, "Ooi, ooi." Then they hear him let the bow string go, but the arrow never hits the side of the house. After that Keseruk says, "Now my arrow has got to the head of that creek over there—now it gets to the Noataka River—now it is someplace else"—he follows the arrow like that. . . . After those arrows went a long way Keseruk would say they were turning around and coming back. "Now they are back to the Noataka River—now to that creek," then the people begin to get excited, they are afraid they will be hit. Keseruk says, "As soon as those arrows come light the lamp. Now!" he says. They light the lamp, Keseruk is still tied up in the same place, but the bow is under the rope on his back and an arrow is stuck in each side of his neck crossed in the middle of his body. The feathers at the ends of the arrows are all that are sticking out. Keseruk has on no clothes—only "short pants." Somebody pulls out the arrow. (If the arrow head is left inside, this means something is wrong.) Then they take the ropes off Keseruk and he picks up the drums and turns around to the doorway away from the light. When he turns back, the two arrows are on top of the drum. Every person looks at those arrows. . . . This might be for asking how many caribou are over on Noataka River. If the arrow comes back painted with blood and caribou hair that means good hunting over there, that is why they look at the arrows on the drum. Sometimes Keseruk does this just for good luck. . . . Mituk was more spiritual than any. When they tied him up, they tied an ax to his feet using new rawhide to bind him tight. When the lamps were out the spirit of Mituk left and the devil came in. As soon as the lamp is out, an eagle screams. Everybody can hear wings striking the inside of the house. Then, finally, the eagle goes out through the roof and it can be heard screaming farther and farther away. While the eagle is flying away, a loose dog comes along and curls up in the house. This means bad luck. People can't see the dog but they know it is there. Then Mituk begins to come flying back, screaming, nearer and nearer. But by the time they hear Mituk land on the roof, the dog has stopped up the hole, and Mituk can't get in. When they light the lamp, the dog is gone, but they find Mituk, still tied up on the roof of the house. They take him in and untie him. Then they see the ax. It is still tied to Mituk, but it is all bloody—with a person's blood. Mituk has been somewhere and killed somebody.

From these three accounts certain salient themes emerge and

re-emerge. The shaman is a chosen person. While selection by descent is in the picture, the basic process is a highly unique, personal, and other-worldly one involving the entrance into the shaman's body of a powerful spirit familiar. There ensues a variable period of turmoil which, depending on one's point of view, could be called an acute psychological crisis, a true mystical religious experience, a physical illness, or a psychosis. The shaman withdraws. He is tormented, afflicted with physical disorders, driven mad, and made to wander over great distances and for extended periods of time in the bush under the most adverse of conditions. In technical psychiatric terms we would speak of the shaman as undergoing a severe regression. It should be noted that the spirit entry into the body of the shaman is not possession in the demonic sense. The spirit is a helping one whose wish is to teach the shaman and support him in his calling. The period of turmoil is thus also a period of tutelage. The shaman gradually develops a body of secret and sacred knowledge from the familiar spirit and from various other secondary spirits who are placed under his command. Coincident with this, the future shaman may undergo a period of instruction with other shamans in his tribe. Finally, he emerges as a shaman, the possessor of secret and powerful knowledge and the master of the paraphernalia and rituals of his profession, and is so recognized by his fellows. As a member of an elite group, his responsibilities are to his tribe; his powers are to be used in their interests. The question of the "bad" shaman with its connotation of malevolence and sorcery is a complex one that cannot be taken up here. Bad shamans occur but rarely and are greatly feared by the people. Their occurrence, if anything, defines and validates the traditional role of the shaman. In western religions we have the Blessed Virgin and the Saints who intercede for us at the Throne of God; we also have our devils. At the request of his people and in the context of the seance with its awe-inspiring shamanistic paraphernalia and its atmosphere of heightened anxiety, emotionality, and suggestibility, the shaman's spirit leaves his body and undertakes immense journeys into the heights of the heavens and the depths of the earth or the sea, there to intercede with a variety of deities on the behalf of the people. The information gained on these odysseys enables the shaman to cure ills, locate food, foretell the future, identify evil doers, predict the weather and bring good fortune.

The world in which the shaman moves, the world of the seance, is a strange one. The limitations of time and space are transcended. High in the heavens resides the God of the Sky. In the depths of the ocean or under the land is the Deity of the Underground. Rocks and stones speak. Men turn into animals and animals into men. It is a world replete with archaic symbolism, in which the shaman journeys the breadth of the universe or around the moon on missions of utmost importance to his people.

The clinical psychiatrist is immediately struck by the similarity between this world and the world of the dream, as originally described by Freud[8] in 1900. Both exemplify the working of the primary process in that they are alogical, permit contradictions to coexist, know no negatives, and are timeless. Such familiar ego mechanisms as displacement, condensation, reversal and symbolization are easily recognizable. It would seem that the experiences of the shaman and the phenomenon of the seance could be formulated in terms of the concept of regression in the service of the ego. By this is implied the ability of an adult to renounce more highly differentiated, logical, systematized modes of thought and revert to primary process modes of thinking in which reality is perceived in a sensitive, unique, and highly idiosyncratic way. This is followed by reversal of the regression and contructive resynthesis of percepts. These data suggest that psychoanalytic dream theory may be able to add a new dimension to our understanding of the complex cultural phenomenon of the shamanistic seance. The world of primitive man is an anxiety-ridden and menacing one. Famine, illness, the lethal aggression of an enemy, and (especially in the Arctic) the vagaries of an extremely harsh and dangerous environment are immediate, omnipresent threats. It is not difficult to postulate in these people deep, intense and often unmet yearnings for the basic securities of life, as well as a concomitant high level of anxiety related to the basic problems of survival. The shamanistic seance can be seen as an institutionalized expression and mode of resolution of these deep-seated needs and fears. I think it is possible to view the seance as a collective or social analogue of the dream of the individual, the psychological content of the seance as quite similar to the dream work, and the trance of the shaman as an example of regression in the service of the ego which plays an essential and valuable role in its cultural context. The sick, the starving, and the frightened take

their problems to the shaman. In the context of the seance with its darkness, throbbing drums, and heightened affective tension, the shaman undertakes his journeys into other worlds in search of a solution. Out of this group regression, replete with a variety of mental operations of a most archaic nature, a solution emerges. It is possible to envision the seance as a collective dream in which the shaman symbolizes his people individually and collectively in their ever-recurring struggle for instinctual gratification and freedom from anxiety.

THE PSYCHOLOGY OF THE SHAMAN

The material cited thus far stresses the ubiquity of shamanism in primitive cultures and highlights the great psychological and social significance of the shaman to the people whom he serves. The seance with its accompanying trance is an institution of central importance in social organizations where it is found. What then can be said of the shaman? What are the personality factors which result in his selection for this unique and responsible role and enable him to discharge it effectively? A great deal has been written about the psychological characteristics of the shaman. Unfortunately, however, most studies have been in the area of psychopathology, with attempts being made to "classify" the shaman according to one or another psychiatric nosology. This has resulted in a division into two rather clear-cut schools of thought: the one,[2,6,11,13] holding generally that shamanistic practices are symptomatic of severe psychopathology and that they represent some kind of institutionalized insanity, while the other[1,4,5,16] stresses the absence of psychopathology, characterizing the shaman as a superior or gifted individual. Both points of view present problems. There are, of course, distinct difficulties encountered when one attempts to apply the diagnostic categories of western psychiatry to another culture. Laubscher[14] points out that delusions of being a shaman or possessing shamanistic powers are just as common among the insane in primitive cultures as are corresponding religious delusions in western cultures. Among shamans, as in every other profession, there are marginal practitioners and outright fakes, who further obscure the picture. Leighton[15] has pointed out that the culture in and of itself can effect the incidence of mental illness by assigning certain people to stressful roles. One would therefore expect a certain incidence of mental disorder among shamans, which should be viewed as a consequence of their role rather than as a

determinant of it. It would appear that the practice of shamanism, like the practice of psychiatry, has its occupational hazards. On the other hand, the characterizations of shamans as stable, of good temperament, responsible members of the community, and psychologically healthy represent subjective, descriptive statements which add little to our deeper understanding of the subject. One of the problems in collecting data in this area has been that the vast majority of field studies of shamanism have been carried out by investigators trained in disciplines other than clinical psychiatry.

Recently, however, several pioneering psychiatric studies have been published which emphasize a careful delineation of the character traits of the shaman, using Rorschach tests and psychoanalytic interviewing as opposed to focusing on descriptive diagnosis. Klopfer and Boyer[12] have published an analysis of the Rorschach protocol of Black Eye, a Mescalero Apache shaman. This was the first such objective psychiatric evaluation of a shaman, and as such is of interest to our discussion here. Analysis of Black Eye's responses revealed interesting trends. He tended to respond from a frame of reference dominated by his role as medicine man and shaman. Such terms as "star," "cloud," and "lightning," which he regularly used as material for interpretation in his relationship with his powers and spirits appeared in his responses to the ink blots. His image of himself was as one "spoken to" or "rendered messages through" by elements in his surroundings. He was described as constantly alert as regarding his relationship to his spirits and powers and as having attained a "symbolic attitude" towards his surroundings. The alertness was seen as a manifestation of "deep anxiety connected with strong and totally unrefined impulsive sensuous reaction." Klopfer and Boyer go on to state, "He identifies his urges with his magic mandate, but is very careful, at the same time, to avoid any ego responsibility for his actions." They felt that this was a personality admirably suited to fulfill the role of "intermediary" in a religious group. His openness to the symbolic elements in his surroundings seemed to be related to the general attitude of the artist, the difference being that the shaman felt himself dependent on outside powers, in the sense of being "used," where the truly creative person or artist tends to see himself as using the outside powers in his creativeness. The picture emerged of a highly sensitive, affective, emotionally responsive man keenly responsive to minor stimuli in his

environment and capable of responding to tides of emotion perceived by him as originating outside of himself without sense of personal involvement or responsibility.

In a later study, Boyer et al.,[3] performed a more detailed comparative study of twelve true shamans and seven pseudoshamans from the Mescalero reservation. A true shaman was recognized as such both by the society and by himself. Pseudoshamans lacked this double confirmation of their status. They were regarded as shamans either by themselves or by their society but not by both. Once again the techniques involved were interpretation of Rorschach protocols, supplemented by psychoanalytic depth interviewing. A large number of interesting observations were made from this very rare material. In general, the true shamans were more like hysterics than the pseudoshamans. The shamans had a greater interest in the theoretical value of objective information and discovered characteristic traits in the given material more quickly than the pseudoshamans. "The more people are egoistically involved and lose practically all characteristics of individual personalities from the Rorschach standpoint, the more likely they are to be found among the pseudoshamans, while the real shaman appears capable of using regression in the service of the ego in Freudian terms. This accounts for the peculiar mixture between hysterical and real creative characteristics to be found in the Rorschach data derived from the shamans and which is absent in those of the pseudoshamans." The shaman tended not to be involved in the interpretation of material on his own behalf, while the pseudoshaman was characterized by his preoccupation with his own gain. The shaman was further characterized by the possibility of the capability of regression for constructive purpose. He had ready access to all levels of psychosexual development and a greater possibility for remembering and re-experiencing earlier events and motions than the pseudoshaman. The authors stressed the presence of ego-controlled availability of primary process in the shaman, something which is intimately related to creativity and showmanship. Such factors seem to be "as necessary for the successful practice of shamanism as they are for the artist whose products are to prove lasting in acceptance and influence, for the true prophet and for the convincing functions of the impostor." The studies reveal that the shaman regards himself as an observer, while his society sees him as both observer and interpreter. He is exquisitely alert for signs through which

his powers approach him with messages of importance. He does not regard himself as the initiator of such messages, but rather as the medium through which the messages pass from the powers to the group in order that appropriate steps might be taken. The shaman translates and interprets the messages according to the language and symbols of his mythic training. The capacity of regression in the service of the ego is an important trait in this respect. The shaman may be compared with the artist in the sense that both have a capability for more ready contact with experience at earlier stages of development and an ego-controlled ability to call upon primary process mechanisms.

Such studies are of enormous interest in the understanding of this complex phenomenon. More of them are needed in other cultures, especially in the circumpolar area where the phenomenon of shamanism is fast disappearing under the impact of westernization.

SUMMARY

In this paper an attempt has been made to look at the phenomenon of shamanism and the personality of the shaman from the standpoint of modern psychiatric theory. It has been suggested that the shamanistic seance is a social institution through which deep seated anxieties and strivings of the tribe are symbolically expressed. The primary process nature of the seance and its relationship in structure to the dream of the individual were developed. In this context, I tend to agree with Eliade that one of the problems that has made the definition of shamanism such an elusive mater is that its basic content is of a very primitive, highly personal, primary process nature. In this sense it is part and parcel of the human condition and may correctly be termed ahistorical. The psychology of the shaman was reviewed. The emphasis was shifted from preoccupation with whether or not the shaman was "insane" or "normal" and focused upon the few existing studies designed to elucidate basic personality characteristics of such an individual. The picture emerged of a man differing but little in his general characteristics from the others in his population, but with some special factors which suited him uniquely for the role of shaman. The shaman was characterized as having an exquisite sensitivity to environmental cues and the capability of regression to primary process levels of thinking and perception. This is not the regression of illness but is rather regression in the

service of the ego which serves a highly important and useful function in those primitive cultures in which shamanism is found.

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THE BORDERLINE CONDITION: A STRUCTURAL-DYNAMIC VIEWPOINT

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The borderline syndrome is a clinical concept gaining increasing acceptance and consensus by clinicians. The consensus is that it can be differentiated from schizophrenia. However, it is still used synonymously by many with such terms as latent and ambulatory schizophrenia[49] and psychotic character disorder.[14] Grinker, Werble, and Drye[18] give experimental evidence for a delineation of the borderline which differentiates it more clearly from other forms of psychopathology. They strongly suggest that the borderline is a specific syndrome which is not characterized by regression. Rather, it involves an arrest of the development of ego-function. Its consistency is marked by what Schmideberg[39] has called a "stable instability." Grinker et al. cite the observations of clinicians who have recognized the borderline syndrome as a confusing combination of psychotic, neurotic, and character disturbances fused with many normal or healthy elements. Using a factorial analysis of psychopathology within the continuum defined by the psychotic and neurotic border as exhibited by inpatients, he designated four subgroups of borderline patients: (1) a psychotic borderline group, (2) a neurotic borderline group, (3) a core borderline group, and (4) an "as if" borderline group. The psychotic borderline is characterized by inappropriate behavior, deficient sense of reality and self-identity, angry or negative behavior, and depression. The neurotic borderline is characterized by overt anxiety, child-like clinging, depression, feelings of worthlessness, and well-entrenched narcissistic tendencies. The core borderline group is characterized not so much by consistent psychotic-like behavior, but rather by confusion, inconsistent self-identity, and vacil-

lating involvement with others (i.e., vacillating between superficially adaptive and negativistic behavior toward others). The "as if"* borderline group showed little spontaneous, self-initiated behavior, but adjusted well to rules and regulations in an unresponsive way. When not adaptive in their selfless way, they were preoccupied with defensive withdrawal and intellectualization. They never seemed to be experiencing or feeling a situation emotionally; rather they seemed to be intellectually aware and conformed to the expectancies of others or the situation without perceiving with a sense of realness. Laing[31] describes this lack of sense of reality as stemming from the creation of a "false self" which protects the inner self that is preoccupied with internal fantasy objects. The psychological structure prevents an intrusion of reality by a creation of a false self which "deadens" by making perception feel unreal and action feel futile.

Instability tends to be the hallmark of the transitional borderline state and has led to its being labelled a "stable instability" (Schmideberg). In addition, others have used such terms as "adaptive overlay" (Grinker et al.), "as if" (Deutsch), and "deadening" of perception (Laing) to describe the borderline state. Knight[30] refers to a symptom pattern resembling descriptively a classical form of psychopathology that is a "forward holding position" masking a borderline state. Similarly, Hoch and Polatin[24] have described a "pseudo" state of pseudo-neurotic schizophrenia. *In general, these and other authors are referring not only to extremely vacillating behavior characterized by wide swings between opposing behaviors and forms of adaptation, but also to a profound lack of emotional depth or sense of not being in the experience. These two qualities would seem to be the basic core of the whole borderline group on a manifest behavioral level and a reported experiential level.*

The main purpose of this paper is to show by clinical illustration how the borderline's vacillating behavior and schizoidal experiencing are related to structural and dynamic processes. The following outline will serve to focus the intent and perspective of this paper:

(1) Borderline states can be distinguished from other forms of psychopathology such as schizoid, depressive, and schizophrenic states by means of a structural-dynamic analysis.

* The term "as if" is borrowed from Helene Deutsch[7] by Grinker et al. and used by them to define a similar affective state in one of the borderline subgroups, the "as if" borderline. Briefly, it consists of a lack of outgoing affect, a lack of well-developed sense of identity and a tendency to imitate others in behavioral expression.

a. While ego distancing defenses characterize both the schizoid and borderline state, the schizoid displays resignation in the face of frustration; the borderline responds with rage.

b. The borderline patient has a more adequate sense of reality than a patient who is schizophrenic.

(2) The disturbance in the borderline condition may be characterized by an ego syntonic fixation at pre-Oedipal levels of identification of an ego with an object. The struggle is between experiencing threatening emotions as a separate individual versus becoming identified with the behavior of others for the sake of protection against overwhelming ego experiences.

(3) In the borderline condition, fear of the loss of a unified ego sense and fear of the loss of relations with others leads to an alternating struggle between the wish for fusion of ego with object and the opposing wish for separation of ego from object.[21]

(4) This conflict leads to poorly defined detached experiences in the borderline and a continued lack of ability to integrate experience. Dynamically, this is characterized by the formation of imitative and widely vacillating behavior patterns.

DESCRIPTIVE DISTINCTIONS OF THE BORDERLINE GROUP FROM OTHER MAJOR GROUPS

Borderline versus Schizophrenia: The borderline group is distinguished from schizophrenia in that the borderline does not show (1) disturbance of thought and perception such as delusions and hallucinations, and (2) psychotic autistic thinking. Although the borderline may approach a precarious state of disintegration, disintegration is a rare event whose infrequent occurrence is marked by transiency and early restitution. As Grinker et al. mention in their psychotic borderline subgrouping, borderlines become predominantly negativistic, socially maladaptive and inappropriate to a level which is *close* to disintegration.

Depression and Detachment: "Depression" within the borderline syndrome can be distinguished from neurotic and many forms of psychotic depression in that in the borderline there is not a convincing expression of anxiety, feelings of guilt, clear expectancy of help from others, preoccupation with ruminative thoughts of self-derogation and outward expression of helplessness.[32] Rather, the borderline's "depression" is characterized by a sense of futility and pervasive feelings of loneliness and isolation.[40,41] There may be a continual

hunger for excessive dependent gratification.* This may provoke angry, rageful demands and accusations of being wronged when exaggerated bids for attention and childlike narcissistic needs are not met. However, there is lacking a self-critical absorption in thought about one's relationships with others so characteristic of neurotic depression and so profoundly displayed in the self-derogating delusions of the psychotic depressions.

SCHIZOID DETACHMENT AS A BORDERLINE EGO DEFENSE

Depression, then, is an inaccurate application of a term to the affective state that exists in the borderline group. Instead, what seems to characterize the borderline group is a feeling of isolation and angry demandingness rather than true depression.

The schizoid, although presenting a personality organization in some ways similar to the borderline in terms of his sense of isolation and loneliness, also presents a pervasive life-long stable personality organization. He does not evidence the same vacillating, unstable behavior as in the borderline, but rather appears to constantly avoid competition and attempts at closeness, *rarely expresses overt anger,* is more entrenched in his preoccupation with an inner fantasy life, and is seemingly narcissistic in his pseudo-self-sufficient attitude.[21] The schizoid does use the same distancing ego defense as the borderline to protect against emotional involvement and closeness to others, but does not present the constantly vacillating personality organization. The schizoid is less likely to form the transient superficial allegiances to groups, causes, individuals, etc., that characterize the vacillating quality of the borderline. There may be, however, considerable overlapping between some forms of the borderline and the schizoid arising from just this commonality of the use of ego distancing defenses to increase interpersonal distance.

To exemplify the differences between the borderline, the schizoid, and the depressive, consider the dream of the patient described by Guntrip.[20] This particular schizoid school teacher described himself as depressed when he disclosed emerging feelings of disinterest with a loss of the sense of hopefulness about the future: "The school superintendent walked away when I arrived and left me to fend for myself and there was no meal ready for me." The patient's remarks

* According to Grinker et al. this is particularly so in the neurotic borderline subgroup.

about the dream were concerning his preoccupation with what he was going to eat, yet in actuality not eating much. This was coupled with feelings of being "cut off," feeling detached from others and wishing to be alone. The content of many treatment hours in this case regarded being faced with superiors who were desired but deserting objects, father figures, including the therapist who prepared no meals for him. The patient continually complained of not being indulged in warm, friendly relationships by his therapist. Like most schizoids, he felt very sensitive to being unwanted. The defense against this intrapsychically determined attitude was to withdraw libido from objects he could not possess and to feel loss of interest, equivalent here to loss of appetite. *There was little evidence of anger and guilt. Rather, there was an attitude of detachment, retreat, and futility reflected in all his expectant relationships with others.* This illustrates the lack of a guilt-laden and ruminative self-critical attitude of the depressive as well as the lack of *anger* so primarily characterizing the borderline personality. There may be hunger for objects in the schizoid, but this induces the schizoid's sense of detachment and resignation after each rejection so peculiar to the schizoid personality. They become more preoccupied with inner fantasy life and intellectualizations. They become more resolved not to risk their sensitive natures and expose their heightened wish for the approval, indulgence, and paradoxical need for the warmth of others.[5] On the other hand, the borderline's response to rejection, a rejection which seems to him to be lurking in every corner, is rageful anger. Thus, in both borderline and schizoids there is overwhelming hunger for some kind of contact with others mixed with fear of rejection. However, it induces detachment and resignation in the schizoid, but rageful anger and spite in the borderline. The paradoxical motives frequently appearing in the borderlines will be discussed later from a psychodynamic point of view.

CASE HISTORY OF A BORDERLINE PATIENT

The following case history of a borderline patient elucidates particular ego states found commonly in the borderline. However, it should be noted that *the ego states, no matter how profound, have limits and structural boundaries. They serve the definite defensive purpose of warding off threatening ego experience. It does not represent a psychotic regression.* This case also illustrates object rela-

tionships related both to unintegrated, vacillating behavior and to forms of borderline detachment.

An eighteen-year-old, attractive, single, white secretary entered treatment complaining of depression, loneliness, and feelings of "emptiness." She began feeling this way six years ago when she became very withdrawn from the family after the birth of a younger sibling. Since then she has had alternating, intense feelings of detachment, isolation, failure, loneliness, worthlessness, and anger. Recently there had been an exacerbation of these feelings at work. Similarly, there had been an exacerbation of these feelings when she entered college a year before. The anger was diffusely directed at everybody around her for what she perceived as their irresponsibility and lack of sympathy for her feelings. Sometimes she felt such all-consuming anger and a kind of uncontrolled omnipotence that she perceived almost simultaneously wishes to destroy and fears of destroying vital, succoring relationships between herself and others. Frequently there was a kind of merging of anger and helplessness resulting in pervasive impotent rage. These states were often preceded, followed, or accompanied by feelings of depersonalization. In college, she began to depersonalize in association with acute anxiety attacks. Initially, these episodes occurred in large crowds such as lecture halls where she felt a sense of distance and a loss of self-feelings, but later these became more frequent even when she was alone. Sometimes depersonalization seemed to occur unaccompanied by any other emotional state than a fear of loss of control. At other times, it occurred with acute panic and a sensation that the walls were closing in on her. At still other times, these episodes of variable duration consisted of feeling small in a large room, the voices of those about her seeming far away, her own almost inaudible. Similar longer lasting episodes occurred outside therapy from which the patient would emerge by superficially cutting her chest and breasts with a razor blade. She cut this area of her body because it was easiest to cover up. Sometimes she terminated episodes of depersonalization by screaming. In therapy, she described at times feeling as though her head was at a distance watching her. The depersonalization became most noticeable during therapy, appearing with the emergence of very primitive anger directed at her parents or her therapist. For instance, there was a recurring fantasy early in therapy of someone being impaled on a long stick which was slowly turned while their skin was being ripped

off. The persons in this fantasy were later identified at different times with each parent. Depersonalization appeared to neutralize destructive fantasies.

Her vacillating, superficial behavior was illustrated by peripheral involvement with isolated islands of friends, each with very different values. On the one hand, there was a nonsmoking, nondrinking religious group; on the other, a "fast-living" crowd who indulged in promiscuous sex and excessive drinking. Her sense of isolation deepened despite her craving for belonging and acceptance by both groups. She not only felt sensitive to slights of group members, but also felt as though she was imitating others in the group in an emotionally wooden way. She felt panicky episodes of isolation combined with depersonalization while a member of either group. She was continually fearful that members of one group would meet members of the other and that she would be "found out." The rapidity of movement between groups and individuals was striking. Just as she invariably vacillated in her attachments to groups, her attachments to individuals were transient. She continually oscillated toward or away from objects.

Her initial feelings of "emptiness" and overwhelming anger started when her mother gave her increased responsibility for her younger brother. The thought that anybody could be attached to her would fan her anger and precipitate withdrawal. A good student, the patient left business school immediately after making the Dean's List. Her parents had begun to expect consistently high grades from her and wanted to show her off to their friends. She luxuriated in this thwarting of parental expectancy because it enabled her not to be constrained by a parental attachment. A suicide gesture tested the therapist's "trustworthiness." Would he accept her no matter what or would he break his contract and communicate with the parents? She had carefully researched the drug ingested for its lethality. Thus, she was continually testing, asking for restraints, but at the same time being offended by infringement.

Her difficulty relating and her sense of detachment with others reached into the sexual sphere. She had periods of promiscuous sexual behavior without orgastic release. In fact, she had never been orgastic. The periods of promiscuity were frequently followed by periods of abstinence because she felt that sex had destroyed a particular relationship. Promiscuity defended against the risk of involvement. At

one point in her relationship with her boyfriend she made an elaborate plan to seduce him. Prior to this, she made a point of carrying her petting activities to a definite preconceived limit before stopping. This deliberate mechanical involvement with others alternated with feelings of being trapped and sometimes panicked by any confessions of concern for her by others. For instance, the same boyfriend, upon confessing his love for her, was met by an immediate stormy retreat and accusation of lack of concern. She maintained complete abstinence from the relationship for several weeks before she would venture to resume it.

Obsessive fantasies were always very intrusive in her everyday life. She had repetitive pregnancy fantasies from early adolescence and wondered whether the growing baby inside her would take up so much room that it would absorb her or swallow her up. After her first experience with sexual intercourse, she forgot her birth control pills used at that time for regulation of menses. At regular intervals thereafter, she vomited after swallowing them.

After a few months in therapy, she announced suddenly that she saw no reason for continuing. Exploration led to her blurting out that she would hurt or destroy the therapist with the feelings she was having about him. She had been able to verbalize anger toward the therapist only with great difficulty. She now admitted to some fellatio fantasies. She felt that therapy was now too intense because of the feelings that it engendered and that if it did not stop it would lead to her being unable to ever be without the therapist. It is interesting to note that this patient resumed therapy some months later with the same therapist, thus illustrating her vacillating object relationships in therapy.

Throughout therapy there was evidence of primitive fantasies of a destructive nature which she could recognize as being due to her hostile feelings. However, they were diffuse and she seldom connected them with any encounter with others. At times there was evidence of a primitive projection of these destructive urges. She would act upon these projected fantasies despite knowing how unrealistic they were. For instance, she lowered her bed to the floor because of her "silly" fear of vampires beneath the bed.

Psychogenetic History: The patient recounted many childhood memories of attempting to come between the father and mother. She

remembered intercepting her father when he came home from work so as to avoid sharing him with mother. At the same time father was thought of as looking upon her as his favorite, he was also perceived as capable of being easily provoked and capable of uncontrollable anger. Memories of her father's sexualized and severe shaming included his taking her pants down in front of the living room picture window so her friends could witness her being spanked. She recalled frequent spankings by the father in which she was positioned in erotic postures while being spanked. The mother was "bitchy" toward the patient and singled the patient out for special punishment to be meted out by the father.

The patient's mother was perceived as cold and aloof. At night the mother's angry remonstrations could be easily heard as she refused the father's sexual advances. There were many open stormy dialogues between the parents. Chaotic family interaction and lack of maternal warmth characterized the family.

Several times during the patient's adolescence the mother referred to her as a whore when she merely dated. She had to sneak out of the house to be with a boy. At one time during early adolescence the patient had painful vaginal adhesions lysed by a gynecologist who invited the mother to note the condition of the patient's vaginal orifice before beginning the lysis. The patient felt extremely guilty that the mother might feel she was not a virgin even though she as yet had not had sexual intercourse. It was characteristic of the mother to oversee situations which had such sexual overtones. The patient felt the doctor had betrayed her to her mother. She also felt an uncanny inability to escape her mother's influence.[48]

The patient's repression of childhood sexual wishes had constantly been threatened by a very seductive father and a cold rejecting mother. Emotions which were sexual in nature tended to be intertwined with intense aggressivity and shame not only through actions such as sexualized forms of paternal punishment, but also through observations of the angry interactions between the parents. The Oedipal conflict normally intensified at adolescence underwent an unusual degree of de-repression when she was forced to play a mothering role with her younger brother. During that time she first noted depersonalization. She also became disinterested in the other feminine household chores she had formerly enjoyed. After that she constantly denied her physical and behavioral resemblance to mother,

while at the same time she felt that her father would have been a more loving father if mother had not been sexually rejecting.

Although behaving in a sexually provocative manner, she vehemently denied having had sexual wishes during adolescence. She felt that older men were constantly attempting to seduce her yet she was provocative toward her father by appearing semi-nude in the parents' bedroom to comb her hair.

In this borderline patient normal de-repression at adolescence was unusually intense and threatened an ego structure that was not well integrated, and had been continually threatened by intense conflict prior to adolescence. Although her personality traits and defenses resembled closely a hysterical pattern, there appeared a deepening of dissociative techniques as well as schizoidal defenses to produce profound episodes of depersonalization and pervasive feelings of detachment. Although she noted the onset of these symptoms at early adolescence, she also had deep feelings of loneliness and had been very withdrawn prior to adolescence.

BORDERLINE EGO FUNCTION

Characteristically this borderline patient possessed a variety of symptoms including feelings of isolation, depersonalization, anxiety attacks, unsystematized paranoid ideas, phobias, vague obsessive thoughts, compulsive behavior, psychophysiologic responses and characteristics resembling the hysterical personality. These symptoms were frequently associated with barely disguised hostile intent. In addition, there was extreme vacillation between symptom patterns as well as striking transiency in her relationships. Her changeableness, in the form of taking on various façades of behavior, accounted for the spurious quality of her behavior. Such behavior façades were illustrated by her feelings of being isolated and imitative within groups. Also, vacillations represented the desperate continued attempt to become involved with individuals alternating with behavior whose purpose seemed calculated to propel the same individuals away. This is illustrated by her expectancy and, frequently, demand for expressions of concern from her boyfriend associated with mechanical attempts at seducing him. The seductions lacked spontaneous depth of feeling. Her response to his proffering of love caused a panicky, emotional retreat lest she become emotionally involved.

In summary, the barely controlled primitive aggressive fan-

tasies, the splitting into contradictory opposite feelings, thinking, and action, the isolated vacillating involvement with others, the transiency in her object relationships, and the many intense episodes of depersonalization all illustrate a continual lack of integration of behavior characteristic of borderlines.[11,16,26,37] Borderline detachment and isolation seem to be the basis of her unintegrated behavior. Her behavior illustrates how a deficient sense of reality and related superficial façades of behavior support attenuated experience with objects.[25] Such schizoidal defenses cause an attenuation of experience in events perceived as threatening to produce overwhelming anxiety.[43]

Despite the severity and variety of symptoms associated with a deficient sense of reality, this borderline patient was able to maintain personal attractiveness, to hold a secretarial position, to receive scholastic honors and to be accepted by many people. Her lack of behavioral integration was evidenced by a predominance of poorly developed ego functions existing with a few well-developed ones. The predominance of poorly developed ego functions are indicative of the continued use of early levels of ego maturation. Such a predominance, if not modified, makes adaptations to later developmental demands very difficult.

PREDOMINANCE OF EARLY LEVELS OF EGO INTEGRATION

Despite a predominance of disturbed ego functions in the borderline there is not the same potential for regression as in the schizophrenic. Behavior suffers from arrest of ego development and there is a greater capacity to remain in contact with reality even though this contact is a deficient one. Development in the borderline has proceeded to a point where there is relatively more differentiation of self from objects both extrapsychically and intrapsychically. One's primary identity is not so profoundly threatened in the borderline. Sadow[38] points this out when he refers to the impoverished ego of the borderline overreacting to excitation with denial and schizoidal isolation rather than psychotic disintegration.

Both the schizoidal isolation and the constantly vacillating behavior of the borderline stem from a longstanding and pervasive psychopathological organization. It has the quality of being characterological and ego syntonic in that it is accepted by the individual borderline with little conscious conflict.* For instance, in the patient just pre-

* Borderlines seldom come voluntarily into therapy. Usually their negativistic, im-

sented, there was little awareness as to her own part in the continually enacted drama of fearful schizoidal approach to people in a group followed by rebuff either by her or by group members with whom she associated. At other times, the object relationship takes the form of sudden overwhelming perception of rejection as when her boyfriend's confession of love for her led to schizoidal isolation mixed with resentment. There may be an impulsive outburst of accusations on the spot or much later as when the fear of becoming affectively involved with the same boy produced a perplexing barrage of accusations of being misused by him. The accusations were completely out of context and inappropriate. Those perceived as being able to give indulgence or the needed interpersonal warmth are the very targets for rage. The very person that is seemingly most cherished or sought is either constantly avoided or becomes the target of inappropriate or unformed rage. The drama gets out of hand whether it be an inner dilemma which threatens to break through the repression barrier or one that is no longer repressed but raging uncontrolled outside one's self. Once rage is externalized, there is little chance of it being dampened or modified because from the start, as in the case illustration, the borderline seems utterly convinced that others are unwilling to maintain constant protection and gratification of demands.

Although the ego formations in the borderline are not the severely undifferentiated ego distortions of schizophrenics, they still serve to reduce dramatically the input of stimuli. Therefore, in the borderline, perception is severely attenuated, communication with objects limited, behavioral integration severely and constantly interrupted in order to maintain and assure a repression barrier. *Instead of severe regression, as in the schizophrenic, there is constant unintegrated behavior existing concomitantly with a tenuous sense of*

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pulsive, deviant, and seemingly spiteful behavior provokes demands for change from the environment. They are frequently made anxious by a sense of detachment which reaches the extreme level of depersonalization, motivating a short-lived desire for therapy. However, the overriding motivation for therapy stems from demands from the environment for change.

Frequently the hospital becomes intolerant of borderlines whose provocative be- Frequently the hospital becomes intolerant of borderlines whose provocative behavior, in its various forms, causes them to be disliked intensely by the staff. The staff then intrudes on the borderline's behavior with counternegativity, sanctions, etc., thus confirming feelings of rejection and bad object relationships. The point here is that the borderline frequently furthers bad object relationships in the therapeutic environment of the hospital as a defense against the threat of overwhelming ego experience in a variety of events as a separate individual.[12]

reality. The predominance of behavior reflecting early levels of ego integration constitutes the constancy, but the unintegrated behavior represented by a denial, lack of impulse control, uncompromising, demanding behavior, vacillations between opposing behaviors, and early forms of projection reflects the changeableness of early levels of ego integration.

DISTURBED EGO FUNCTION AND EARLY LEVELS OF EGO INTEGRATION

In borderlines there is little evidence of a prolonged loss of reality, but, rather, a relatively deficient sense of reality and loss of differentiation. However, there is clearly a deficit in various ego functions with a comparatively few well-developed ego functions existing amid a predominance of poorly developed ones. The case history cited illustrated how this borderline patient was able to maintain personal attractiveness, to hold a secretarial position, to receive scholastic honors, and to be accepted by many people despite the severity and variety of symptoms associated with a deficient sense of reality. Kernberg[27] has pointed out that borderlines can present with many severely maladaptive forms of behavior: polysymptomatic neuroses of an inhibiting, bizarre nature, polymorphous perverse sexual trends, prepsychotic personality structure, impulse neuroses, addiction, and certain more poorly organized infantile, narcissistic, and masochistic personalities. *The symptoms presented are far less important as the core psychopathology than the ego disturbance that the symptoms mask*. As Knight[30] points out, the symptoms are a superficial "forward holding position" behind which lies the relatively deficient sense of reality. Grinker et al.[18] have a similar idea in mind when they speak of the superficial "adaptive overlay" of the borderline. The latter authors also illustrate this by citing the ability of some borderlines to conform quickly and easily by taking on the behavior of leaders and authorities of the immediate treatment milieu. This ease of identification is superficial and resembles closely the "as if" character structure described by Deutsch.[7] That it is superficial is attested to by the ease with which one adaptive pattern is exchanged quickly for another in different settings or changes in milieu.

The case history illustrates the phenomenon to which these authors refer. The patient often felt emotionally wooden in a group or when she vacillated between groups which had contradictory atti-

tudes. Even though she accepted and professed the attitudes of the religious group when with them, the next day she was able to enact and seemingly accept, without reservations, the attitudes of the sexually promiscuous group. The mechanical seduction of her boyfriend represented a superficial emotional engagement. When this maneuver brought the threat of involvement she retreated into a façade of anger and dramatic schizoidal isolation. At adolescence this behavior was intensified by dramatic episodes of depersonalization whenever affective involvement threatened.

The transiency of her object relationships and the schizoidal dissociative affect were illustrated by her vacillating imitative behavioral façades. There was a lack of clarity of what she meant to others and what others meant to her. There was a lack of a well-integrated self-concept and self-identity consistent over time and existing as a unified sense of self.

Gruen[19] cites the difference between neurotic states and certain prepsychotic states as due to the lack of identity in the form of feelings of separateness and ego synthesis. Authors such as Bychowski, Despert, Bettelheim, and Laing [1,4,6,31] cite theories of the ontology of the self based on arrest of ego development because of a lack of psychological safety. A person with such an ego structure does not derive a feeling of separateness or unity of self as the outcome of the experience of competition, rage, self-assertion, and love that is part of the Oedipal conflict. The outcome of this defeat is an arrest of development through fusion. Such a person does not progress by transcending infantile developmental stages. He does not develop by retaining neurotic traits in order to resolve the Oedipal conflict. The satisfactions of self-direction following the development of a feeling of independence are not obtained. He does not truly experience the Oedipal conflict. The developmental arrest is associated with the outbursts of hostility and eroticized passive compliance so typical of a condition where *identification with another tends to exclude the ability to fully experience one's self.* By experiencing one's self is meant being capable of experiencing affect without a deadening of perception. It means being able to fully experience feelings, thoughts, and activities.

Rather than a feeling of separateness in self-identity allowing full experiencing, there is in the borderline a condition comparable to that described by Gruen. In this sense, identification with another

becomes a psychological defense and resembles a fusion with the self of another. The thoughts and emotions of another become one's own. In a psychotic, this is profoundly the case. In the borderline it is of lesser degree, but, nevertheless, has a tremendous influence on the behavior of the borderline. He may struggle between eroticized passive compliance or fusion, which represents a psychological annihilation of the self, and sudden, frantic attempts at experiencing his own thoughts and emotions.

The struggle between independence of self and fusion of identities is dramatically illustrated by another borderline patient.

SECOND CASE HISTORY OF A BORDERLINE PATIENT

This twenty-one-year-old Summa Cum Laude graduate student came to the psychiatrist's office because she could "not make a decision" and felt as though she were "falling apart." She was seductively attractive and pathetically clinging in her efforts to have the psychiatrist decide for her about whether to return home to live with her parents and get a humdrum clerical job, or continue in graduate school where she felt there was no future for her. Actually, she had quit school the day before by formally withdrawing from all her course work, but still was faced with engaging in some reflection about what this abrupt decision meant to her. She at times became angry at the lack of definiteness on the psychiatrist's part concerning a decision. At other times, she was pathetic, clinging, and even refused to leave the office when there was no satisfactory answer to her demand for a decision. This occurred even at the end of the very first interview. The vacillation from one possible justification for a possible course of action to another was mercurial and left her still more pathetic, demanding, and clinging. Rapid alternatives in opposing behavior characterized this encounter. Active attempts on her part to conform to the deliberations and justifications of another person alternated quickly with very oppositional deliberations and justifications which *seemed* to be her own. She was at the pinnacle of a dilemma. The increased anxiety forced her to accept the protection of home with a mother "who would welcome me back with open arms"—the mediocrity of a clerical job was due in part to an impending marriage. The problem of approaching sexual intimacy and close involvement was compounded by her recent social involvement with coworkers in educational field work. This socialization,

which she had pushed off into the future or found excuses to avoid for many months, was now imminent. It was also evident that her life was characterized by many unfeeling encounters with others as well as continuous abrupt changes in behavior. Her fiancé had become more and more disillusioned by her behavior. She was no longer the seductive little-girllike college student in his eyes, but, rather, a pathetic, demanding, extremely clinging young woman whose moods were impossible to comprehend. She was driving him away and even though she was resentful and rageful, she seemed to be aware dimly that she was doing this. Her provocative behavior toward her fiancé incurred his rejection. The rejection in turn produced resentment which justified to her the wish for the protective home environment and identification with her mother's wish to have her home. Yet she was simultaneously struggling against these wishes in order to retain her independence and individuality.

VACILLATING BEHAVIOR AND EARLY LEVELS OF EGO INTEGRATION

There is masking of deficient ego function in the borderline by unintegrated vacillating behavior. The ego deficiency is felt by them as a detached, unfeeling involvement with others. They have an experience with others, but isolate themselves emotionally from experience. Their overwhelming sensitivity to others leads to schizoid detachment and rageful anger than appears to be a callous, indifferent response. The sensitivity is derived from an ever-present perception of a hostile depriving world.

The psychogenetic data of the first case history revealed that parental behavior and attitudes tended to stimulate many conflicts in the patient concerning sex and aggression. The unusual and traumatic punishments administered by her father were sexualized by his seductiveness. This was compounded by an anti-sexual suspicious mother who lacked maternal warmth and giving.* Both paternal

* Bowlby[3] offers data concerning the mother as a "psychic organizer" necessary for ego growth in the first three years of life. Fairbairn, Guntrip, and Winnicott[9,22,46] cite the various causes of detachment from object relationships. Guntrip seems to summarize the points of view established by all concerning emotional deprivation in the statement: "To be capable of development to full maturity the ego must begin to differentiate out of a basic experience of full security in the mutual identification of a mother and infant."[22] Pre-Oedipal primary identification with full security is basic for a unified sense of self and maturing differentiation of the self.

and maternal behavior towards the patient generated continued narcissistic injuries and created conflict that made her more vulnerable to the usual adolescent de-repression. This patient lacked a great deal of the optimal conditions she needed for the sense of security basic to continued ego development.

The resultant sensitivity to others breeds seemingly insensitive schizoidal and spiteful behavior. Such insulating behavior is anxiety-provoking itself and leads many times to acting out of fantasies designed to increase ego feeling and ego involvement through increasing a deficient sense of reality. This may be done through various provocative behaviors such as aggressive angry behavior, promiscuous sexual activity, and psychopathic behavior. It may even be done by cutting one's skin in order to dramatically achieve the desired increase in a sense of reality. These behaviors have been illustrated in the case histories presented.

However, there may be another reason for the sudden vacillations in behavior and appearance of dramatically contradictory opposites in behavior. It is related to the narcissistic, childlike, demanding behavior which is masked, but only barely, by the unintegrated identifications, behavior patterns, and object relationships. It has its wellsprings in the conflict between, on the one hand, the motivation to be separate from the wishes, thoughts, emotions, and influence of others, and, on the other, to be fused with them. It is illustrated by the borderline patients who feel a sense of "emptiness" or a sense of "nothingness" or a vast "void." They may have fantasies about having a hungry child clamoring inside them for food, attention, and love. At times, the object felt to be inside them assumes more than a mere metaphorical meaning, but is something which they become identified with consciously.* This object hunger becomes overwhelming, but at the same time dangerous if too clamorously expressed. It is dangerous because it may cause the disappearance of the object for which one is so earnestly and desperately in need. This is due to an ever-present overdeveloped need for primary identification or symbiotic fusion with objects. The need to create the omnipotent, nar-

* Object relationships influenced by intense conflicts not only thwart the development of relationships with others as a separate individual, but also are based on the dominance of early ego structures. Szasz[45] alludes to the utilization of concrete symbolization and the body as an object in expressing conflict and intense wishes too dangerous to acknowledge consciously. This occurred in the pregnancy fantasy discussed in the first illustration of this paper.

cissistic ego state may in itself devour the object and, therefore, cause a loss of the object.* Succinctly, not only do borderlines have a sense of *being bad,* that is, a self-esteem determined by the vagaries, whims, and choices of others, but also *they feel their impulses are bad,*[20,34] that is, destructive to others and ultimately to themselves. In a simple interpersonal schema, this is illustrated by the guilty, fearful, readiness-to-be rejected approach to others which provokes the very response most feared, hate and rejection from the object desired. The other alternative is ego loss by identification with the object. Such loss of the ego is probably responsible for the schizoid detachment of the borderline which is felt as a sense of "emptiness." He and those he is drawn to feel identified so that he feels "swallowed" and loses his feelings of separateness. Such a feeling of ego loss was reported in the first case history wherein the fantasy of being pregnant led the patient to feel that what was inside might swallow her up. This feeling expressed in body language her overwhelming fears of ego loss if her wish to be fused with others was realized. In a sense it was a symbolic representation of her wish for total mothering care by being identified simultaneously as both the mothering figure[2] and the one mothered. However, in the borderline it is perceived as a threatened ego loss because the outcome is a fear of loss of separateness from others when such a wish for fusion is finally consummated.

This is dramatically illustrated by another male borderline patient who lacked the capacity to express or feel his own fear or rage toward father, but could express the fear and rage felt by his mother toward his father. Toward his father he felt helpless to express or feel any emotion. His conflict was still a pre-Oedipal one and required the development of independence before the Oedipal conflict could be resolved. The development of a separate self requires the dissolving of primary identification, that is, a separation and individuation through differentiation of ego and object.

Intractable negative transference reactions are often the result

* Kernberg[26] suggests that it is the overwhelming experience of unmodified pregenital aggressive fantasies that is one of the crucial factors affecting the ego structure of borderlines. However, it may be the destruction of the object relationship itself or the feared recapitulation of the trauma occurring in a previous threatened loss that is most crucial. The threat of just such an overwhelming wish for fusion was reported in the first case illustration when the patient felt compelled to stop treatment because of the intense feeling she would hurt or destroy the therapist.

of such lack of differentiation between ego and object in the borderline.[36] The patient does not form a "working alliance"[17] by reflecting on the possibility of his catalytic behavior vis-à-vis a parental representative, but, instead, attempts to transform the therapist, as well as others, into parent figures.[44] What is effective in therapy with borderlines is to interpret that emotional reactions of the patient are different from those of the therapist even though the therapist may react similarly on his own.[42] This prevents the projection of emotional states onto the therapist with the resultant fusion. Hopefully, in such a therapeutic setting the patient will eventually become convinced of the preservation and viability of the therapist despite the experiences of emotion separate from those experienced by the therapist. *Differentiation between ego and object must be the major thrust of therapy in the borderline.**

The dramatic vacillation of behavior and the phenomenon of contradictory opposing behaviors is due to the lack of differentiation between ego and object. It creates a chronic dilemma. The individual so affected can neither be in a relationship, that is, experiencing it without feelings of isolation, nor out of it, without in some way facing the utter loss of both ego and object.[21] On the one hand he may destroy the object by exhausting love or destroy his sense of identity by losing his individuality through fusion. On the other hand, he may risk separation from the object and the ensuing threat of overwhelming ego experiences by dissolving the identification holding him a prisoner in a dilemma. The latter is the way out of the dilemma and holds the ultimate possibility for autonomy and growth of a capacity for cooperative independence and mutuality. It is the only way a real ego and a unified sense of self can be developed.

If the dilemma is not resolved an approach-avoidance conflict continues and becomes more embedded in the personality organization.[5,8,33] The approach towards a relationship to maximize psycho-

* Related to such therapeutic techniques of differentiation of ego from object is the development of a therapeutic relationship in which not only are feelings interpreted, but also emotions are well tolerated, although not indulged or allowed free rein. In addition, ego boundaries can be reified by support of areas of competence and by discussion of courses of action in the here and now. Extreme neutrality is not well tolerated and tends to stimulate acting out rather than fostering the desired confident autonomy.[31] The countertransference becomes of crucial concern in treating these difficult patients and is a whole subject in itself. Authors such as Kernberg,[28,29] Winnicott,[47] Guntrip,[23] Spotnitz,[42] Giovacchini,[15] Federn,[10] and Marie C. Nelson[35] seem to have the most enlightening and definitive points of view concerning the treatment of the borderline.

logical safety through identification increases the intensity of motivation of avoidance. On the other hand, separateness from the relationship engenders anxiety which intensifies the motivation for remerging into the relationship. *The resulting phenomenon is a continual rushing into a relationship to fend off the anxiety of feelings of isolation and detachment and subsequently breaking off for fear of losing one's ego or one's object.* This vacillating behavior and transiency of object relationship is the basis upon which superficial identifications are taken on and discarded with such rapidity by borderlines. This is the reason for descriptions of borderline characteristics such as "adaptive overlay," "as if," and "forward holding position."

The outcome of this behavioral phenomenon with such a psychodynamic dilemma can further schizoidal detachment as a perceptual defense against the feelings of loss, hopelessness, and helplessness that it engenders. This can set up a kind of vicious cycle in which feelings of isolated detachment can lead to further narcissistic demands and desire to merge with protecting objects in order to quell the anxiety existing as a result of different forms of borderline ego integration.

SUMMARY

An understanding of the borderline phenomenon can be reached through a structural-dynamic analysis. The lack of integration and schizoidal experiencing represented by contradictory behavior and behavioral façades distinguishes the borderline from the depressive and schizoid conditions. The borderline structurally represents an arrest at early levels of ego development when ego and object tended to be fused. Although this does not represent a psychotic regression it does cause continued attenuation of experience as well as a consequent lack of ego integration. The struggle is between experiencing threatening emotions as a separate individual versus becoming identified with the behavior of others for the purpose of protecting against what are perceived as overwhelming ego experiences. From the structural-dynamic viewpoint there is basically a fear of the loss of a unified ego sense and a fear of the loss of relations with others leading to an alternating struggle between the wish for fusion of ego with object and the opposing wish for separation of ego from object.

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THE AGE OF AWARENESS

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As a result of the discoveries of psychotherapy, we are now in the midst of the most profound revolution in human relations in the history of mankind. While this revolution stems from Freud and the psychoanalysts, it does not stop with them. Its directions can be indicated, yet its ultimate outcome can scarcely be visualized. We can only predict that even though much has changed, the greatest changes are still to come.

In order to have control over these changes it is necessary to be explicit about our goals, and to keep them clearly in mind. The purpose of this paper is to describe these goals in as much detail as possible. It is time to formulate a psychoanalytic philosophy of living.

I.

To begin with let us explain the title. Ours is the age of awareness, in which for the first time we see how sick mankind is and always has been. As a result we can formulate a rational approach, based upon adequate scientific evidence, by which a new creative kind of living can be substituted for the old neurotic ways in which men have always been immersed.

The contrary to this position is that what is new in our age is the anxiety, not the awareness. It is true enough that each new day brings more evidence of the enormous burden of anxiety that modern man carries with him. Rennie and his co-workers[14] have estimated that some eighty per cent of the ordinary New Yorkers

* This paper was presented at the American Psychological Association, Symposium on Societal Therapy at Chicago, September 1965.

they studied were disturbed, a considerable proportion pretty seriously incapacitated. Hendin, Gaylin and Carr,[6] in a routine investigation (the purpose was methodological, not substantive) of average nurses, discovered that they all had problems, some quite severe. They could only call their sample a "non-patient" population, to get away from the meaningless cliche of "normal." Going to other countries, Leighton[11] has documented the ills that befall Americans, Canadians and Africans. In a fascinating compilation, Ari Kiev[8] has brought together many varieties of counterphobic magic employed by contemporary "primitive" societies to counteract the ubiquitous fears of their peoples. While the psychiatric situation in the Soviet Union is obscured by the political need to appear happy and the Pavlovian form of magic, what goes on there appears to be reasonably similar to what goes on in our own country (see Winn's recent collection of papers).[15]

If we search for the promised land of Nirvana in the past, the results are just as devastating. As the year 1000 A.D. approached, a large percentage of the population of Europe was convinced that the world was coming to an end. The great French historian Jules Michelet described the spiritual atmosphere of the Middle Ages as one of despair.[12] The witchcraft persecution which finally led men to substitute physicians for clergymen as "healers" of the mentally ill sounds far more pathological than the usual delusions of a hospitalized schizophrenic in our own day. Consider for example how an attractive woman is to defend herself against the charge of kissing the devil's behind on a lonely street corner while she is looking the other way. In such proceedings the judges (members of the clergy) were considered to be "sane," while the accused was "possessed," and usually doomed whatever she did.

And lest it be thought that merely turning the clock back a hundred years would lead us to an era of sanity, we need only be reminded that this was the period which gave birth to Freud. Historians have all too naively assumed that the average man in times past was sane; there is no objective evidence to corroborate this assumption, and a wealth of data to contradict it.

Nor have anthropologists fared any better with the obscure preliterate (to avoid the insidious comparison of "primitive") societies which they have studied. The ubiquity of magic covers up feelings of overwhelming fear, as Charles Odier has shown in his classic work.[13]

Cannon[1] has even postulated a physiological mechanism to account for the phenomenon of "voodoo death," or literally dying of fright, occasionally reported by field workers. It is true that on rare occasions some societies have been found which exhibit some reasonable degree of mental health, but they are so few and far between that anthropologists shudder when they have to discuss the problem seriously. Fortunately they have developed a mystique of scientific detachment which allows them to sidestep the entire question.

The list of sociological, historical and anthropological data could be extended indefinitely. Enough has been presented to document the thesis that with isolated exceptions man is and always has been a frightened, unhappy, neurotic creature who at best has controlled his anxieties by an elaborate magical ritualistic mumbo-jumbo. And the number of millions who have been sacrificed to prove that one form of magic is superior to another staggers the imagination.

It is this view of the human condition which must be used as a backdrop to place psychotherapy in proper perspective. That very few people are receiving psychotherapy need be of little concern; penicillin is a powerful drug even though there are millions who do not have access to it. Correctly seen, *psychotherapy is the first scientific attempt to make people happy.*

This thesis must be elaborated in two directions. First of all, scientific psychotherapy must be compared with nonscientific. And second, psychotherapy must be related to the social structure.

Psychotherapy, like medicine, is as old as mankind. But it has never before been based on an adequate knowledge of the exact sciences. In fact, the statement is often made that before the advent of modern science, medicine was more likely to do harm than good, and the same is true for psychotherapy.

The science which psychotherapy is based on is modern psychology, particularly psychoanalysis and its development (rather than deviations, a misleading concept). As "true" scientists, we like to repeat with Newton that we are like children playing with pebbles on the beach, with a vast unknown universe lying before us. Yet in all justice we must also aver that the understanding of man acquired since 1900 is enormous. It is by no means final. Quite the contrary; it continues to grow and change at a rapid rate. But that does not alter the fact that there is now for the first time a solid

and substantial body of information which illuminates the psychotherapeutic enterprise.

There can be no doubt that prescientific psychotherapy, like prescientific medicine, at times obtained results. But it is hard enough, as many keep reminding us, to clarify the results that we get today. What happened in other eras can only be conjectured.

The relationship between psychotherapy and the social structure is a complex one. Freud's thesis in *Civilisation and Its Discontents*[3]—that culture necessarily leads to neurosis—is a one-sided oversimplification. Actually, in the same work, Freud also said that while whole civilizations could be and have become neurotic, psychoanalysis is in a position to provide the corrective measures for this condition. Fromm[5] in his book *The Sane Society* has tried to elaborate on some of the implications of Freud's work.

In order to depict in sufficient detail the connections between psychotherapy and society, it is necessary to have clearly in mind the kind of ideal which modern psychology can now propose. This ideal differs in a number of significant respects from the so-called "normal adjustment" which the unanalyzed individual at best achieves.

These differences between the analytic ideal and the social ideal can serve as a measure of the maturity or mental health of any given society. Inasmuch as it is the goal of psychotherapy to help the individual, so far as possible, remold himself in the light of the analytic ideal, this process thereby serves to transform society. *In the larger scheme of things, Societal Therapy is the ultimate goal of the psychotherapist.*

II.

It is time to be explicit and spell out the details of the analytic ideal. As this is done, the real agreements and disagreements in the field can fruitfully be brought to the fore.

1. The pursuit of pleasure is a positive good. Man is a biological organism, with built-in physiological mechanisms that lead to pleasure or pain.

It is surprising how many religions and philosophies have contradicted this simple principle. The Ten Commandments say nothing about the pursuit of pleasure. Buddhism begins with the proposition that all life involves suffering; that it also involves pleasure is ignored.

Specialists in ethics have generally held a hedonistic philosophy

in poor repute. Insofar as there is any valid argument against the hedonistic position, it is that excesses of pleasure will inevitably lead to suffering. This is undoubtedly correct. But it does not alter the fact that with proper foresight the judicious pursuit of pleasure leads to a happy life, while the pursuit of suffering leads to an unhappy one.

The principle involved here is a simple generalization of a common psychotherapeutic procedure. People in our society tend to suffer far too much. Frequently, as a reaction, they go in for pleasure bouts—drinking, sex, drugs—only to wake up with a hangover after it is all over. Apart from the unconscious meaning of the outlet chosen, the trouble lies with the lack of foresight, not with the pleasure as such. In psychotherapy the goal is to help the person acquire more control over his capacity to secure pleasure. Sometimes, because of the weak ego of the patient, it is necessary to forbid certain types of pleasure temporarily, not because they are bad but because the patient cannot handle them. As the ego becomes stronger, the taboo is lifted. Whatever the technical therapeutic means are, the ultimate goal is to allow the individual to enjoy life more.

Pleasure is age-specific. A great deal is known by now about the developmental process, both physiologically and psychologically. One age's doing is another age's undoing. Fixation and regression could be viewed as processes which deny the age-specific character of pleasure. Life should be looked upon as a journey from one form of pleasure to another; he who lingers too long becomes neurotic. Generally speaking, the overaccentuation of some form of pleasure which is not suitable to the chronological stage of the individual has its roots in some interpersonal disturbance.

Another significant point is that the refusal of any age-specific pleasure has lasting effects on the further history of the person. Oral deprivation may lead to death (marasmus). When the infant remains alive, it frequently suffers from a feeling of severe deprivation which remains for the rest of the person's life.

This developmental interconnectedness, in which the outcome at any one stage depends very heavily on what happened earlier, makes it extraordinarily difficult to generalize about normal behavior at any point in the person's life. It also provides an important theoretical foundation for a basic thesis of this paper, to be elaborated later, that psychotherapy is an essential feature of the human enterprise.

2. *Sexual gratification should be encouraged.* Of the numerous pleasures available to man, none has led to more bizarre repressive measures and more needless controversy than sex. It is still necessary for the psychotherapist to reaffirm that sexual pleasure is one of the most important sources of happiness available to the human being.

Although sex, like any other id gratification, is now seen as a complex result of ego factors, rather than a simple instinctual release, this should not alter the proposition that other things being equal, sexual pleasure is a life-affirmative value. In view of the tendency of many recent writers to lump sexuality with addiction, alcoholism and other acting out disorders, it is desirable to be as specific as possible about our position in this respect.

We have long taken it for granted that masturbation in childhood and sexual intercourse in adolescence are perfectly normal activities. They are harmful only where pursued to excess, or where they have undesirable consequences.

The desirability of sexual intercourse in adolescence, however, while privately encouraged by the great majority of psychotherapists, meets with formidable social obstacles. Restrictive laws, pregnancy, abortion, venereal disease are among the many problems that must be handled. Here the analytic ideal is squarely at odds with the social. It appears that in spite of all the difficulties, the analytic ideal is gradually winning out.

However, while it is winning out behaviorally, it has by no means won out psychologically. Time and again we see adolescents and young adults who are consumed with guilt, both conscious and unconscious, about their sexual activities. For the fullest enjoyment of sexuality this guilt must be overcome. That can only be done psychotherapeutically.

For large groups in society, sexual pleasure in marriage has become a socially sanctioned ideal. Numerous books are freely available which give detailed instruction on how to secure such pleasure. Yet for all that it must be remembered that there are large classes in society, e.g., the devoutly religious, who are still as antisexual as their forefathers were five-hundred years ago. There is still a long way to go before society fully accepts sexual gratification even in marriage.

When it comes to extramarital intercourse, we find opinions

rather sharply divided. But a disappassionate evaluation of human experience should convince us that for most men monogamy is neither an attainable nor a desirable ideal.

No doubt there are wide individual differences here. Some people seem to be content with a single relationship, either because it is inherently so satisfying or because they find so much happiness in other activities. For many others this is by no means the case.

It is of course true that many patients arrive at the analyst's office burdened by the guilt of an extramarital affair. Often this guilt is conscious. Yet it is equally true that many others arrive burdened by the deadweight of marital fidelity. Usually guilt here is unconscious. Yet the pattern of marital fidelity is as destructive to one kind of person as that of marital infidelity is to another.

Anthropologists have shown that ours is among the most restrictive of all societies with regard to extramarital sexuality. Of the various sexual taboos this restriction has probably been affected least by the progress of psychotherapy. There is no theoretical or clinical evidence that the restriction should be maintained with all possible force. Nor is it to be supposed that the spread of extramarital intercourse would materially affect happiness in marriage. What we are witnessing today is a transformation of all values, including those pertaining to marriage. It can only be said that the attempt to make marriage satisfy all the emotional and sexual needs of both partners fails more often than it succeeds.

3. Man should release his positive emotions. Man is a feeling animal. In order to be happy, he must experience a wide range of positive emotions, such as joy, excitement, love, enthusiasm and the like. The acceptance of pleasure and sexuality lays an adequate basis for these emotions; their denial blocks them.

There is little room for argument here, except that the image of a feeling person is contrary to the social ideal of our society and many others. Here again, psychotherapy steps in to change the social structure.

4. Love should predominate in human relationships. The development of human relationships proceeds from the helpless dependency of the infant to the full-bodied love of the mature individual.

Because of the numerous neurotic meanings attached to the word "love" numerous misunderstandings arise here. I have else-

where[2] suggested that love goes through five stages: attachment, admiration, physical (sexual) enjoyment, total enjoyment, devotion. For the adult the most appropriate definition of love is mutual enjoyment.

Such a definition conflicts with the social ideal, and has numerous corollaries which conflict with it as well. Primarily, psychological insight is sharply contradictory of the notion that it is possible to love one person and one person alone for an entire lifetime. Love should be viewed as a force within the individual, an active power rather than a passive reaction. To "love" is healthy; to "fall in love" is neurotic. If this were recognized, the whole fabric of interpersonal relations would undergo an extraordinary transformation.

5. Hatred and other negative emotions are harmful to the human spirit. Hatred, resentment, envy, jealousy, and other negative emotions are mainly reactions to frustration, not instinctual drives in the same sense as sexuality. The goal of psychotherapy is to eradicate these emotions, or at least to reduce them to a minimum. While it is true that our efforts in this respect are often far from successful, in a goodly percentage of cases the person does manage to free himself to lead a more constructive life.

At this point a theoretical issue of considerable importance arises. If hatred is an instinctual reaction, it can be reduced or neutralized, but not eliminated. The task of the therapist then is to help the patient release his hostilities.

Many therapists do work within such a framework. The net result is that they produce hostile people, which is both socially and individually undesirable. If, however, hatred is the result of frustrations, a consistent lessening of these frustrations will lessen the hatred. Since hatred and its concomitant violence are central to all social problems, this issue becomes a vital aspect of the interaction between psychotherapy and society.

6. *The individual should have a meaningful role in his family.* The nuclear family, derived from the biological fact that it takes a man and a woman to produce a child, is a universal phenomenon. Perhaps for that reason a meaningful role in the family becomes a psychological desideratum.

While the family itself is as old as history, its contribution to human happiness has only recently been recognized. Many revolutionary movements, such as Christianity, Communism, Nazism at

some point deliberately tried to destroy the traditional family structure. Even psychoanalysis in the early days emphasized the harm that family conflicts did to the child, particularly those surrounding sexual repression. It took a long time to redress the balance.

Every person in the family derives benefit from the particular role that he plays in it. Two dangers arise here, which psychotherapy routinely handles. One is the unstable family, where the normal roles are disrupted for one reason or another. The other is the excessively stable family, where there is no real expression of feeling or spontaneity. More recent research has shown that these families operate on the basis of scapegoating one member. Typical are the parents who "sacrifice" themselves for the children who then feel terribly guilty because of the awful burden placed upon them.

7. *The individual should have some sense of identity in the larger society.* Once a sense of identity in the family is achieved, it should be extended to the larger society. Man must have some sense of community. Perhaps the major polarity which man in our society faces is that between the individualist and the organization man. Each has advantages, each disadvantages. Psychologically, what seems to count more than anything else is consistency in the choice of role.

8. *Man should be engaged in some satisfying form of work.* Traditionally work has been regarded as a necessary evil. The English "gentleman" (a gentle man—one who is not cruel), the Spanish "caballero" (man on horse), the French "seigneur" (lord), the German "Herr" (master) were all social ideals, which still maintain themselves, opposed to work. Their image has been assimilated by the average man who seeks to retire at an earlier age.

In an otherwise worthless book, La Piere[10] has coined the term "The Freudian Ethic" for the philosophy of contemporary psychotherapy. It is contrasted with Max Weber's classic formulation of the Protestant ethic.

The Freudian ethic, like the Protestant, sees work as a positive good. Work is a way in which man uses his abilities and relates constructively to his fellow men.

Modern psychology has stressed the active character of man's nature, as opposed to the earlier image of a *tabula rasa* on which anything can be written. Work gratifies this need for activity.

Many sociologists, following Marx, have maintained that modern man is alienated from his work. While this is often true, there is

little reason to believe that it is so much more typical of contemporary man than of men in previous ages. It is a sociological parallel to the psychological myth that ours is the age of anxiety.

It could rather be maintained that for the first time man has sufficient command over the forces of nature to choose the areas in which he will exert his greatest efforts. Thus it becomes the task of a well-ordered society to regulate the work activities of its members in a manner which will optimize mental health. It is at this point that the insights of psychotherapy can make a meaningful contribution.

9. *Some form of creative activity is desirable for everybody.* Here it is first necessary to distinguish between inner and outer creativity. Inner creativity is a novel experience for the individual, although it may be old hat to everybody else. Most typically, it is seen in the growth of a normal child, which proceeds by a series of creative experiences.

Outer creativity is an achievement which offers something new to the outside world. Psychotherapy indicates that everybody has the capacity for inner creativity; that for outer is relatively limited. In this discussion we are interested mainly in the inner form.

The psychological need for creativity arises essentially from the unmanageability of the id. There are simply too many instinctual impulses; many simply cannot be expressed in a socially acceptable manner. A creative outlet provides the most desirable vehicle for channeling these impulses.

10. *Psychotherapy is a lifetime process.* In one form or another psychotherapy should be continued throughout the person's life. The reason for this is that psychotherapy provides a growing self-awareness, and this growth process need never stop. At each new stage in life new problems arise, new conflicts emerge, new decisions about life have to be made. In all these situations self-understanding is the most important tool at the individual's disposal.

By psychotherapy here we do not mean only the formal face-to-face process. Self-analysis, group contacts, meaningful individual relationships with mature people—these are all part of the psychotherapeutic undertaking. However, from time to time a return to some form of brief formal psychotherapy would be indicated for many people.

Ideally the proposals made by Freud in his paper "Analysis Terminable and Interminable"[4] could be applied to every analysis.

There Freud suggested that every analyst should go back to analysis every five years, while in the interim periods self-analysis would be of great value. In view of the ways in which analysis has changed since then, the time period can certainly be altered, but the spirit of Freud's paper is one with which we can still be in essential agreement.

III.

Having sketched, in a regrettably brief fashion, the main features of the psychotherapeutic ideal, it is now time to examine the relationship of this schema to the contemporary social structure. The consistent application of this ideal to alter society is what I call *societal therapy.*

In the early days of psychoanalysis the emphasis was mainly on the id. Much vital information was uncovered. But it was realized later that id material can be fully understood only in relationship to the ego.

Since the advent of ego psychology in 1923, much knowledge has been accumulated about the genesis of the ego in the family structure and about the relationship of the ego to the larger order of society. In fact, it can be said that the relationship between the individual ego and society is similar to that between the id and the ego. Neither can be understood without the other.

Sociologists have long been critical of psychotherapists on the grounds that they ignore the social milieu too much. Conversely, psychotherapists have been critical of sociologists because they tend to leave the individual out. No full science is achievable without an integration of the two fields. Fortunately both the conceptual framework and sufficient factual information are at hand to effect such an integration.

This paper is an excursus in Utopiology, if we may be permitted to speak of the science of Utopias. It seeks to determine how society can be altered to make men happier. Its thesis is that society can be so altered by a consistent application of psychotherapeutic principles. Unlike other Utopias, however, it frankly admits that to many of the questions raised we have no final answer. Without devaluing in any way the answers which have been found, it concentrates rather on the directions in which these answers can be found.

It needs no special argument to show that in terms of the ten

desiderata of the good life listed above, our society turns in a very poor performance. Much serious thought must therefore be given to how psychotherapy can help to effect a change in this deplorable state of affairs.

In the *New York Times* of July 18, 1965, Professor Ivan Morris has described the post-war Japanese movement of "Soka Gakkai," which means absolute happiness. The Soka Gakkai is an evangelical movement which preaches nonviolent tactics, a neosocialist political philosophy, a free sexual attitude and a strong sense of interpersonal solidarity. So far it is not too different from other evangelical movements in the history of mankind.

What is most intriguing in Professor Morris' description of the Soka Gakkai is the widespread use of group therapy. There are frequent group meetings in which members unburden their problems to each other's sympathetic ears. Morris calls these "therapeutic discussions." Whether this novel feature is the result to any extent of the contemporary Western emphasis on psychotherapy he does not say. It would be most useful to get more details of how this group therapy works out.

No doubt the most novel point made above is that psychotherapy should be a lifetime process. This needs fuller elaboration.

Scientific psychotherapy was introduced into Western civilization by Freud. While some psychoanalysts eventually recognized that psychotherapy is closer to philosophy and education than to medicine, the acceptance of psychotherapy has been mainly on the basis that it is needed for "sick" people.

This point of view must undergo considerable alteration. The sickness of people resides primarily in their inability to lead a meaningful life; the symptoms are a consequence. It is therefore necessary to assert in a forthright manner that psychotherapy seeks to teach people to live happily. Its antecedents, its philosophy and its methods all differ radically from the orthodox medical treatment of illness.

How effective psychotherapy is is a most difficult question. Three assertions can be made. First of all it is an extraordinarily powerful tool, undoubtedly the most powerful ever devised to change the human mind. Second, in spite of its power, its results are all too frequently disappointing. And third, most psychotherapists from Freud on have been convinced that prevention is far easier than cure.

Psychotherapy is an education in self-understanding. At the

present time nobody completes this education once and for all. Whether that will be possible when children are brought up in a more sensible manner remains to be seen.

Personality is formed in interaction with other people. It can only be changed to any significant extent by new interactions with new people. Self-analysis, except as part of a broader psychotherapeutic process, is extremely limited; without formal psychotherapy, i.e., systematic communication with a trained person, it is almost always useless.

Society must therefore make provisions for the training of a large number of psychotherapists. If there were a hundred times as many therapists as there are now, the number would still be insufficient.

Yet it is a remarkable fact that there is no standardized training for psychotherapy, that in fact the candidate must go through a large amount of material, whether in psychiatry, psychology or social work, which is irrelevant or positively harmful to the ultimate goal of doing psychotherapy. A prime requirement must therefore be the clarification of what makes a psychotherapist, to set up programs that provide the necessary training.

In point of fact there is enough broad agreement by now as to how the therapist should be prepared for his task. This can easily be put together into a formal program leading to a recognized doctor's degree. The Kubie plan is one way; many similar ones have been suggested.[7,9]

It has been argued, and rightly so, that our resources are inadequate to produce the number of psychotherapists needed. While this is certainly true for the foreseeable future, it should not be looked upon as an argument against therapy, as has been done in some quarters, but rather as a challenge to make best use of the available resources.

Here there are two possibilities. First, group therapy can be developed on a broader scale to reach larger numbers of people, even though it is doubtful whether the group experience is as deep as the individual; and second, nonprofessional leaders can be trained to handle social groups of various kinds.

Something of this sort seems to be going on in the Soka Gakkai movement. It can be done here on a more rational basis. The prime needs are to produce more meaningful experience within the individual and to get away from stultifying and boring experiences in the group. For both of these purposes the psychotherapist is best fitted

to serve as the main agent by which our society can effect major changes in its inner life.

The desirability of replacing feelings of hate by feelings of love is recognized by all therapists. As a beginning, then, a Society of Love could be created. This Society would make use of individual psychotherapists, group therapists and lay group leaders to engage in regular discussions of the personal lives of the members. Theoretically only such regular discussions extended over long periods of time can have a permanent effect.

In other words, psychotherapy should become part of an organized movement to reorganize the social structure. Psychotherapeutic social reform can be contrasted with the various other approaches which have been offered.

First of all, every society tells its members, explicitly or implicitly, that if they observe the ethos of the community they will be happy. Any unhappiness, the general assumption holds, must come from extra-social sources—magic, sorcery, agitators, brain pathology, and the like. The trouble with this assumption is that it is simply untrue. For the most part unhappiness which does not conflict with social custom too sharply has simply been ignored.

Modern psychosocial research has solidly established the fact that each society creates certain kinds of unhappiness which it considers perfectly normal. We can speak in every case of an adjustment neurosis and of a maladjustment neurosis. Only the latter has been given much consideration historically; for an understanding of the former we must turn to the insights of psychotherapy. What we are talking about here is the adjustment neurosis of our own society.

Second, social reformers have generally been interested in institutions rather than people. Get rid of private property, the Marxists argued, and you will have done away with hostility. History has not borne them out. Unionize the workers, give them good living conditions, the liberal labor movement held, and they will be happy. The facts are otherwise.

This should not be construed as any argument against social reform. Quite the contrary. The institutions of society should be altered in many ways, but it is important to realize what will be accomplished by such institutional change and what will not. The inner discontent of man is not materially affected by such outer changes; it can only be attacked internally.

Third, religious thinkers have generally urged men to forget the world and find the kingdom of heaven within: "Give unto Caesar that which is Caesar's, and give unto God that which is God's" was the solution in the early days of Christianity. There are two difficulties with this approach. On the one hand, it is impossible. Religious freedom can exist only within a certain social order, and religion cannot forget the social order. The Romans tolerated Christianity, but the Christians themselves, when they became the Caesars, did not tolerate any form other than their own versions, often pretty narrowly defined. And second, the inner happiness which religion offers is either illusory or not the kind which appeals to the sophisticated man of today (or other days, for that matter). It is too opposed to indestructible human needs, such as sexuality or the need for communication. It rests upon guilt imposed by authority, rather than self-actualization.

If there is a real external problem, the patient in psychotherapy must learn how to handle it. On a larger scale, if there are oppressive social conditions, men must feel strong enough to change them, sometimes, if necessary, by force. Not turning the other cheek, but the normal use of aggression is what is required.

But again following the analogy of individual psychotherapy, the social change alone does not bring happiness; it merely paves the way for it. It must be followed up by inner change if happiness is the goal.

As an example, take the case of nationalism. Freedom from external oppression has always been a cry which could rally men to the flag. Yet once freedom is achieved, as it has been over and over again, the same problems recur.

On the other hand, psychotherapy differs from religion in that its philosophy of living is closer to man's essential nature. A further difference lies in the recognition of the human need for communication, and the provision of adequate means for satisfying this need (group therapy, group discussions under trained leaders).

Paradoxically, psychotherapeutic social reform thus steers a middle road between traditional external change of the social institutions and traditional religious inner transformation. Based on a scientific understanding of human nature, it seeks to build a better world by a persistent gradual change of the present one. Its major contribution lies in the recognition that there are many inner conflicts which can only be changed psychotherapeutically.

The other parts of the psychotherapeutic philosophy have already been discussed at sufficient length—pleasure, sex, feelings, promotion of love, restriction of hatred, family role, identity, work and creativity. None of these is novel in the history of man; what is novel is their unification into a cohesive way of living.

Other philosophies, both past and present, have over-emphasized one aspect of living at the cost of others. Thus pure hedonism does often lead to excesses which are harmful, e.g., it has frequently led to a great deal of violence. The advocacy of feeling by the Romantics was all too frequently coupled with intense suffering, since that is a feeling too. On the other hand, the bourgeois image of the family has created people who look like characters in Grant Wood's pictures—lifeless, without zest, spontaneity or feeling.

What the psychotherapeutic philosophy stresses is balance. To some extent a person must participate in each aspect of the ideal to have a happy life. No doubt the different ingredients will vary for different individuals, but it is well to remember our clinical experience that extremes in any direction produce much misery.

It may be objected that a psychotherapeutic vision of human happiness is completely unrealistic at the present juncture. And yet a vision, even if it cannot be realized in the immediate future, serves a constructive purpose. It is better to light a candle than to curse the darkness. History has played a curious trick on mankind in that physics and psychology both have reached a stage of world-shaking maturity at the same time. Just when man discovered the means by which he could effect his own destruction, he was also in the process of perfecting techniques for securing his salvation.

The physicists have responded to the challenge by forming political action committees. Although as scientists we are always humble about the vastness of our ignorance, we should also be cognizant of the magnitude of our achievements. Psychology, in spite of all its limitations, has come along far enough to offer a positive program for happiness. It is time for psychology to organize for political and social action. The psychotherapeutic philosophy described here could serve as a basis for such action.

It is not fashionable for an intellectual to talk in positive terms of America. Yet it is well to remember that it is in this climate and this alone—the United States and Western Europe—that psychotherapy has been able to flourish. Psychotherapy is a positive plan for

happiness, an outgrowth of the humanistic philosophy which for centuries has represented the finest ethical ideals of Western civilization. In the cold war, we have ignored this important psychological weapon, exporting as a rule the worst that America has to offer rather than the best.

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THE THERAPEUTIC STANCE: AN ERIKSONIAN APPROACH TO DIAGNOSIS AND TECHNIQUE

Bernard A. Green

I. INTRODUCTION

This paper is an attempt to describe a diagnostic schema that is meaningfully connected to psychotherapeutic technique. It is an attempt to bridge the gap between diagnostic formulations and the specific stance taken by the psychotherapist. The issues contained herein grew out of a dissatisfaction with the lack of functional guidance provided for the therapist by traditional diagnostic thinking. So often, in my opinion, after hearing a case presented, well worked up, intelligently discussed by the staff, the listener is left with the question of how all these labels or formulations are related to technique.

The diagnostic thinking presented is based on the notion of ego needs. It is almost a truism that therapeutic technique should be tailored to a patient's needs. Balint was stimulated to write his book *The Basic Fault* to deal with the lack of fit between the analyst's "otherwise correct technique and a particular patient's needs."[1] The wide variety of patients who are treated psychotherapeutically presents us with a wide variety of needs that to a significant degree must be met before these people are willing to commit themselves to therapy and an open dialogue with the therapist. This paper is an attempt to describe ego needs and to relate particular needs to the need fulfilling responses the therapist can offer. It is an attempt to answer the question, "What do you do when. . . .?"

In order for technique to be talked about meaningfully, the goals that the techniques are designed to accomplish must be specified. I will discuss two goals sought after in psychotherapy: (1) establishing the therapeutic relationship, and (2) promoting ego

growth. I will offere a dignostic schema based on Erikson's theory development that will, hopefully, allow the clinician to respond more appropriately to his patients in order to maximize these goals.

II. GOALS

A. Establishment of the Therapeutic Relationship

It is fair to ask why a relationship is necessary in psychotherapy. In its simplest form the answer is that a relationship is necessary so that the patient will listen to what the therapist has to say and eventually this will establish the conditions such that the patient will listen to himself. My own image for a discussion without an appropriate relationship is almost any cocktail party conversation. I have never convinced anyone of anything at a cocktail party. While I talk my opponent marshals his arguments and as he talks I marshal mine, both of us listening only enough to relate our counter-arguments to what the other was saying. This has been described by Abraham Kaplan, the philosopher, as a duologue. In therapy, however, we attempt to establish a different atmosphere, an atmosphere where the two people listen to each other and to themselves. In therapy we attempt to establish the conditions for dialogue.

A dialogue exists when each of the two people involved is open to the other. By open, I mean that each is willing to be influenced by the other, influenced in two ways. In the first place, each is willing to be emotionally affected by the other, allows himself to respond affectively to the other and allows himself to feel what the other is feeling.

The second type of influence is that each is willing to allow his sense of self, his definition of himself, to be affected by the views of the other. We spend a greater or lesser portion of our energies programming people to view us in a certain fashion.[8] The view we elicit generally corresponds with a view of ourselves that we wish to maintain, be it positive or negative. This implies that to a greater or lesser degree, feedback from others is essential to the definition and maintenance of our view of ourselves. People who are important to us are those whose words we allow to affect our self-definition. The analysis of resistance in analytic psychotherapy may be seen as the attempt, in part, to rid the patient of his defenses against defining the therapist as "important"—important in the technical sense of one whose definition of oneself is incorporated into the self

definition. Resistance analysis aims at freeing the capacity of the patient to react affectively. It is only when the patient will allow the therapist's behavior to affect him emotionally that the therapist can have an impact. H. D. Duncan[3] describes the anxieties attendant upon intimacy or significant communication:

> . . . each moment of significant communication is a moment of deep anxiety. . . . Significant audiences make us miserable or happy because we accept their definition of us as our definition of ourselves. . . . We wait in anxiety because our social identity will be determined by their acceptance, rejection or indifference.

The next question we must deal with is how a relationship characterized by dialogue develops between patient and therapist. Freud[6] described it in the following way:

> The first aim of the treatment consists in attaching him (the patient) to the treatment and to the person of the physician. To ensure this one need do nothing but allow him time. If one devotes serious interest to him, clears away carefully the first resistances that arise and avoids certain mistakes, such an attachment develops in the patient of itself, and the physician becomes linked up with one of the images of those persons from whom he was used to receive kindness.

Freud is speaking not only about the development of the transference, but also about the development of what Greenson calls the "therapeutic alliance."[9] Attaching the patient to the person of the therapist means that the patient trusts the therapist enough to allow him to become "important."

But to many of the people seeking help from psychotherapy, "time" and a "devoted serious interest" are not enough. To assume they are sufficient is to make a diagnostic appraisal of ego development and defensive mobility that simply does not apply to everyone. Freud's recommendations apply to a specific class of patients, the transference neuroses. Many of the patients we now try to help do not fit into the category of transference neurosis. Many of our patients are afraid of people, afraid of being hurt, of being dominated, afraid of having their personalities submerged. These fears are simply not calmed by a neutral, interested stance on the part of the therapist. This is so partly because these people have egos which are not "reasonable"—they are not always capable of distinguishing between

what they know and what they feel; or, the distinction being made, the one does not affect the other. Their stance is maintained by an attitude of caution. The therapist may *seem* like a good person but the patient feels that he has been hurt so badly before that he is extremely cautious and unwilling to accept things at their face value. When one is terribly afraid or the stakes are very high, excessive suspiciousness seems to have greater survival value than openness and trust.

People who ask for psychotherapeutic help differ in their capacities and preconditions for establishing a relationship characterized by trust and openness. The question must again be posed; how do you establish such a relationship? Trust develops when two people respond to each other's needs. A therapist helps a patient achieve openness by fulfilling the patient's ego needs. Those of us trained in the analytic tradition were taught not to react overtly to the patient's communications. We were taught to delay, analyze and deny the patient all gratifications except interpretation. However, in the schema to be presented it will be argued that this "nongratifying" stance is in itself a means of gratifying the patient's *ego needs*. Trust develops as danger diminishes. By responding to the patient's needs, the therapist *demonstrates* that he is on the patient's side. The key question then is how to conceptualize ego needs such that therapeutic technique aimed at establishing and deepening the dialogic relationship flows from the patient-therapist encounter, so that the therapist's response is tailored to the patient's need at that moment. We will take up this question after we look at the second goal of therapy, promoting ego growth.

B. Promoting Ego Growth

Psychotherapy addresses itself to the ego. A person comes for help because the way in which he is handling internal and external demands causes him discomfort. Therapy is aimed at the ego in that it tries to help the patient change his characteristic way of handling conflictual demands. How does a therapist help a patient change habitual modes of dealing with conflict, i.e., the ego? One approach is that he offers the patient a nonthreatening relationship that both reduces stasis anxiety, thus allowing defenses to be minimized, and promotes ego growth.

I would like to discuss ego growth by examining the concept

of the "narcissistic neuroses," i.e., those patients declared by Freud to be inaccessible to analysis. John Gedo describes the narcissistic neurosis as a condition "in which a transference neurosis *capable of resolution by interpretation* did not develop . . ."[7a] (italics added). I have found this a particularly stimulating definition for it immediately raises the question of what it takes in the way of ego capacities to resolve a transference by interpretation. A transference neurosis may be said to exist when the patient sees the therapist as a primary source of gratification for unfulfilled wishes. The patient's behaviors aim at getting the therapist to gratify him. The patient directs behaviors at the therapist with the desire to achieve his goal (G_1) of getting gratification from the therapist. An interpretation may be described as the therapist offering the patient a different goal (G_2) —the goal of looking at the behavior just produced and understanding it. Let us try to describe what it takes for the patient to accept the therapist's goal (G_2) as a valid working contract:

(a) *Trust:* The patient wants surcease from suffering. He feels he will get it if the therapist will gratify him (G_1). The therapist offers G_2 with the tacit understanding that the pursuit of G_2 will lead to cure. The patient must be able to trust the therapist enough to accept his lead and substitute G_2 for G_1.

(b) *Attitude to "Now":* This describes the ability to delay gratification, the ability to tolerate not seeing the therapist as a real source of gratification. Several aspects of the situation may magnify in the patient's eyes the importance of gratification *now*. One is the *amount of pain* the patient *feels*. The greater the pain the patient feels the more adamantly he will demand gratification to ease his pain. A patient in intense pain, fear, anxiety, depression will have great difficulty substituting G_2 for G_1. Another vector contributing to the now quality of the patient's desire is the magnitude of the stakes. The ability to delay depends on the stakes for which he feels he is playing. The patient who fears castration is playing for far lower stakes than one who fears death or the dissolution of his identity. Thus the higher the stakes the less the ability to delay gratification or accept substitute goals (G_2). Another factor is the number of sources of real gratification the patient has other than the therapist, e.g., wife, family, friends, significant work and play situations.

(c) *Splitting the Ego:* This refers to the patient's ability to

observe himself, to take himself as an object. Not all patients are able to do this consistently. Patients with an intense sense of *now* seem unwilling and/or unable to observe themselves. Also patients with severe superegos, patients who equate observation with condemnation, seem unable to observe themselves. They cannot allow themselves to find out anything new about themselves for this creates too much anxiety.

(d) *The Power of Words:* To resolve the transference by interpretation means that we use words to affect the patient. We must ask if words mean as much to the patients as they do to the therapist. For some patients "actions speak louder than words." This is exemplified by a clinical incident described by Tarachow. He was dealing with a young male patient with strong, compulsive impulses to murder his mother. He (the patient) never knew whether or not he could trust Tarachow until the patient heard him urinating in the center of the toilet bowl. The patient felt that this demonstrated Tarachow's lack of fear—fearful people urinate "on the side of the bowl, making it silent." Tarachow states that after this *demonstration,* "treatment moved along very well."[15] Also we want to know if the patient has had experience with words as faithful conveyers of the state of the other or with words as a means of merely confusing, obfuscating and trapping (i.e., as a vehicle for constant "double-binding").

(e) *Relation to Reality:* An interpretation in essence says to a patient, "here are the reasons why you see me as you do." The implication is that the patient really knows better but is motivated at the moment to distort. Does the patient really know better? With some we cannot assume that they have a "reasonable" ego. If we ask a patient why he sees us in such and such a way and the patient in essence replies "Why not?" then the transference cannot be resolved by interpretation alone.

The goal of promoting ego growth stands out in high relief in considering patients who cannot resolve their irrational perceptions by interpretation alone. What is to be done to resolve and alter the maladaptive relationship patients attempt to establish with us? What we have to offer is a different relationship, a relationship that on a moment-to-moment basis is designed to alter the patient's need for a pathological relationship. Further, the relationship the therapist offers is designed to foster the development of those attitudes and

capacities that are requisite for nondestructive relationships. The task then becomes one of diagnosis, i.e., understanding what each patient needs from us in the way of response in order to change pathological attitudes and structures.

III. A DIAGNOSTIC SCHEMA

Following Gedo's[7] lead I have turned to Erikson's schema of ego development to conceptualize both ego needs and the environmental responses that further ego growth. Gedo classified types of therapies, e.g., psychoanalytic, supportive, and adolescent, on the basis of Eriksonian notions. He concluded that different approaches were necessary depending on whether the patient was dealing with a current age-appropriate developmental task (child and adolescent therapy) or the late sequelae of the unfavorable resolution of a childhood crisis (supportive therapy, psychotherapy, psychoanalysis). In dealing with pathological sequelae, he separates approaches according to whether the patient has been successful in mastering the crisis of autonomy: if unsuccessful he recommends supportive therapy, if successful, then psychotherapy or analysis. The approach presented here uses the Erikson schema not to classify therapies but to classify moment-to-moment, session-to-session therapist responses dealing with the particular needs contained in each stage of ego development. It is clear that the therapist may be supportive in an interpretive therapy and interpretive in a supportive therapy. This is a moment-to-moment decision.

Erikson[4] describes the ego from the standpoint of the development of basic attitudes relating self and others which lead to an individual's unique manner of "loving and working" in the face of the press of individual wishes, socially accepted channels of expression and societal demands. I turn to Erikson because a review of my own clinical practice shows me that some patients I feed, some I give advice to, some I ask to accept my values in place of their own, and some I listen to patiently and interpret their desires to be fed, advised and judged. There is a similarity between how I conceptualize the patient's needs to which I respond and Erikson's schema. Furthermore, the meeting of ego needs goes on regardless of the content of our words. Some patients took my observations of their behavior as if I were starving or feeding them, some as if I were criticizing them, some as starting points for their own observations and thoughts.

One must distinguish between wants and needs. My twelve-year-old son may *want* to stay out past 10:00 repeatedly, but I respond by not allowing him to because I feel that he *needs* external controls from me. This distinction is often a hard one to make. People put enormous pressure on us to provide for their wants, but ego growth is fostered by responding to the ego needs of the individual. A want is an experiential phenomenon. A want is defined in terms of the tension felt within the person himself, i.e., they are aware that they want something whether or not they know exactly what it is they want. A want or drive is relatively independent of the external world except as the external world serves as satisfier or frustrator of that drive. A need is defined by society, it stems from a tension outside the person. An ego need is a potential in the person which evolves with time and which needs environmental stimuli in order to emerge and develop. Society defines what the person needs in order to become a functioning and accepted member of that society. Thus a child knows when he wants to eat and then he senses that eating is necessary for survival. He does not feel he needs to learn to read. Society makes the judgment and then tries to convert imposed need into inner want. A therapist's values are operating explicitly when he decides what his patient needs in order to grow.

What follows is a brief sketch of Erikson's schema of ego development with an emphasis on the appropriate growth-enabling environmental response:

Basic Trust: A person struggling with the issue of basic trust is dealing with the question of whether or not the world can and will supply comfort and nurturance. The person feels that he cannot regulate and deal with his own needs and level of discomfort and so his attention is focused on the other, the provider, as the source of comfort.

The responses that help a person reaffirm basic trust consist of caring and nurturing in a mutually regulative way, that is, the provider gives when signalled to do so. But there is also some development in the capacity of the receiver to delay so that providing is done at a time and in a manner that also fits the needs of the giver. The provider becomes a stable source of comfort, one who provides constancy, continuity and a sameness of experience. This leads to the receiver developing a trust in himself, in the capacity of his own facilities to cope with stimuli.

An example is provided by Knight[13] in his treatment of a schizophrenic patient. After vainly urging the boy to lie down because his continual standing had caused badly swollen feet, Knight picked the boy up and put him on the bed. Knight reported in a communication to Hoedemaker: "I did regard the actions on my part at the time as a change in technique from that of the always patient, infinitely tolerant but passive therapist, to the relatively tolerant and active therapist, who would not remain passive while his patient behaved in a way to damage himself and defeat his own interests."[10] Knight was responding intuitively to the issue of basic trust posed by his patient.

Autonomy: Autonomy describes the outcome of separation–individuation.[14] A person dealing with this issue wants to feel free and separate but is afraid of the possible consequences of that freedom, i.e., whether or not he can control his urges, whether he can be a "whole being" without the symbiotic tie to the other, whether or not separateness can be established without emotional support being withdrawn by the significant other.

The growth-inducing responses include firm outer control and the setting of realistic limits for the patient. Often these limits refer to limits of ego boundaries, i.e., where the patient ends and other people (particularly the therapist) begin. That is, autonomy is not only preached by the therapist but practiced in his manner of meeting the needs of the patient.

Hoedemaker reports physically ejecting a schizophrenic patient from his office after she refused to believe that he had terminated the analysis because she took a step he had told her not to. He quotes her as saying later, "Thanks, I'm glad you understood about weaning," and, "The most important single event of my life was when Dr. Hoedemaker threw me out of his office."[10a] After presenting several examples of limit setting in analysis, he drew the following conclusions:

> This behavior (on the patient's part) required the analyst to set limits in order to avoid having the boundaries of his professional activity breached. Such limit-setting resulted in more realistic behavior and perception in the patient's ego functioning . . . After a time, the patient regards the ability acquired from the analyst as his own. . . . An important product of this limit-setting is that the patient is able to identify with he analyst, and more sharply define the realistic boundaries of his own ego apparatus.[10b]

Initiative and Industry: I put these two together because I have not been able to distinguish them clearly in my own clinical practice. Initiative involves an active reaching out in the sense of aggressive attempts to deal and cope with the interpersonal world. Erikson uses terms like "undertaking," "planning," and "attacking" to convey the sense of this issue. Industry seems to deal with issues further removed from interpersonal interaction. It deals with work and accomplishment with the "things" in the world. Industry is the attempt to consistently and systematically carry out tasks and goals—"steady attention and persevering diligence" are required.[4a]

The basic therapeutic approach here is what Berne calls "decommissioning the parent."[2] The propensity of the patient to feel guilty and inferior is questioned. The internalized set of values by which he judges himself are gently questioned. In dealing with patients struggling with these stages I sensitize myself to their use of the words "should," "should not," "ought," and "ought not" and question both the origin of these terms and their validity in the present circumstances. In essence I am offering my less rigid values as at least a temporary substitute for the patient's values.

Identity: The task here is integration of all "past identifications with the vicissitudes of the libido, with the aptitudes developed out of endowment, and with the opportunities offered in social roles."[4b] The growth-enabling response is a nonjudgmental autonomy granting distance—the psychoanalytic stance. The message conveyed by the analytic stance is that the therapist is willing to accept any solutions, any combinations of identifications that the patient wishes to call "himself" are "o.k." The patient feels that he cannot be, cannot do, because of current external influence, e.g., punishment or withdrawal of love. The therapist's distance highlights the internal and noncontemporaneous nature of these restraints.

The value of this stance has been demonstrated to me by patients who, after initially complaining of my silence, have later told me that they appreciated the asmosphere so created. It enabled them to find their own answers which, in fact, lay within them as my silence had indeed suggested. For these patients my refusal to advise and offer opinions on the various life problems conveyed my respect for their capacity to deal with them. A factor influencing Freud toward granting his patients the right to associate freely was his being asked by one patient not to interrupt her in her train of thoughts.[11]

Intimacy: Here the individual tests out his identity by allowing himself to become committed to another and responsible for the commitment. Intimacy calls for some sense of fusion between people without a sense of ego loss. It calls for openness without fear. I believe the appropriate therapist response here is of the "Come on in, the water's fine" variety. The therapist sets an example through his commitment, empathy and openness. This is a combination of teaching and example that is characteristic of the Encounter and perhaps the Guru.

The examples I have given of the use of this diagnostic schema may have given the impression that the schema is used exclusively to distinguish patients from one another. I would like to emphasize that although people may be characterized as exhibiting a particular ego need over relatively long periods of time and the terms of the schema may be used in the same way that standard diagnostic nomenclature is used, i.e., this patient is *an* hysteric, *an* obsessive etc., this is not necessarily the case. Rather, patients may change their needs from session to session and at times from moment to moment within a session.

This certainly raises the issue of diagnosis, i.e., how do you know what the patient needs? My own experience is that I have often not known what I was responding to until after I had responded. Not that I always responded appropriately. But I always did respond to the patient's communications of ego need. What I have to offer diagnostically is only a rough sketch of the signs of regnant ego needs as I have categorized them to myself thus far.

Basic Trust: Persons dealing with this issue are characterized, in my opinion, by an air of distance. It is as if they had given up expecting the world to respond or, and this has been more common, they feel they cannot allow themselves to admit that anyone can be important to them. Fairbairn describes the schizoid personality in terms of three characteristics that I believe apply also to the description of people who lack basic trust. He speaks of an attitude of omnipotence, an attitude of isolation and detachment and a preoccupation with inner reality.[5] I often do not recognize the distance between the patient and myself till after many sessions when I realize that affectively I am no closer to knowing this patient than when he first walked in.

In consultation interviews I believe this issue is regnant when

I am left with the impression that although I worked hard to help the patient, nothing I had to offer was enough. I am left with a sense of not having anything of value to offer when I consciously thought that I did. As I approach, they withdraw. It's like the sound of one hand clapping.

Autonomy: When people are dealing with this issue they make me feel that they are daring me to set limits, that the only way I could care is to set limits. They ask for concession after concession but if I once say no or set a limit (establish the firmness of my ego boundaries and the separateness of the two of us) then they will fight me tooth and nail. The issue posed to me is whether I should sacrifice my own comfort and desires in order to accede to the wishes of the patient. Until the issue becomes clear, I always feel hardhearted and uncaring if I chose to favor myself. Another sign I use comes under the heading of "dependency." A patient will sometimes present a problem for the therapist to cure and he will make it clear that it is the doctor's job to do the work. I consulted with a young man whose hands had been shaking more and more over the past year. He was working as an illustrator and he found that whereas he could sketch easily and competently when at home, his hands shook when he was at work. This man had felt "inferior" for as many of his twenty-seven years as he could remember. He was constantly trying to show that he was as good as the next man and further that he was as good as the "best of them." When I pointed out that he was trying to be perfect he readily agreed and asked if most people weren't motivated by the same goal. I attempted to question his values, the values by which he subjected himself to such tension. This got us nowhere. I was "hassling" him as he had been hassled all his life. Afterward I realized that the fact that the pathogenic values (as I saw them) were ego syntonic, staunchly so, should have led me to realize that what he needed from me was not a "decommissioning of the parent" stance, but rather an inquiry into the rather curious position he had assumed, namely that I cure his symptom but leave the attitudes and behaviors supporting the symptoms out of the endeavor. That he assumed this position suggested that I consider his needs to be related to autonomy rather than initiative/industry and that what was needed from me, given my view of the mechanisms of psychological change, was a limit

setting confrontation of the impossibility of the "contract" he was offering.

Initiative and Industry: The two previous categories revolve around desire—the patients convey that they need or want something from me in the way of help in dealing with the world. With these two issues I find myself spontaneously offering something. I am always struck by how hard on themselves are the patients dealing with these issues. They have a pervading sense of self-consciousness that is filled with "oughts" and "ought nots." I usually try to get them to be less hard on themselves. People dealing with these issues seem to take two stances: that of the indefatigable worker who is tense when at rest and that of the "lazy," apathetic type who is uncomfortable with his lack of achievement.

Identity and Intimacy: These people are generally well functioning, autonomous, industrious, and trusting. They may feel unsatisfied with themselves, not at peace with themselves or in "touch" with others on a fulfilling basis. But their discomfort rarely affects their ability to function at home and at work. When these issues are regnant I find it easy to take an interpretive stance. These people are able to make use of my interpretations and are perfectly capable of having their desires met in the extra-therapy environment.

Admittedly these diagnostic statements are simplistic and incomplete; however, they are a beginning in the description of manifest ego needs.

IV. SUMMARY DISCUSSION

This paper grew from a consideration of my own clinical practice. I found myself responding intuitively to different patients in different ways and rather than chide myself for inconsistency and unorthodoxy I tried to undertand some of the factors within the patients to which I was responding. Erikson's schema of ego development and the growth inducing responses of the environment seemed to provide at least some measure of consistency and lawfulness to the interaction between myself and my patients and it appeared useful in categorizing clinical interactions reported in the literature. I have used the notion of ego-oriented growth inducing responses to try to understand why the therapist responds as he does. It is clear that this is not all the therapist does. The therapist, for example, spends

a good deal of time dealing with the resistance to change. I have simply not focused on this aspect of technique.

Implicit in this presentation is the notion of the therapist's intuitive response to the patient's need. I have found in supervising beginning therapists that very often their first impulses in response to the patient are accurate reflections of the patient's ego need. More often than not these impulses are suppressed or defended against. I am saying that ego needs are communicated clearly whether or not they are perceived consciously, and the growth potential of the therapist's response seems to depend on his own upbringing and his willingness to be open to the patient in every sense of the word.

V. EPILOGUE

I have written this paper in the first person. I chose this style to emphasize the point that this is not a scholarly paper in the traditional sense, i.e., the justification for the existence of the paper stems not from the literature in psychotherapy; rather the justification comes from my own experience as a therapist. I turned from looking at my behavior in terms of what I "should" have done according to this theory or that theorist to an attempt to understand *what I was indeed doing.* What therapists do and what they say they do are, in my opinion, two diffeernt things. This was dramatized to me by a colleague, an analyst, who gave one of his patients a chocolate chip cookie at the end of a session. I had never seen that "technique" described in the literature. This belief in a "dualism" in science has recently been given articulate airing by Kessell.[12] I want to convey that the therapist's intuitive reactions are important data to be taken seriously and to be made public, explicit, and if possible, systematic.

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AFTER THE ANALYSIS: A NOTE ON THE POST-TERMINATION PHASE

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I am reporting a case in which dramatic therapeutic changes occurred in a patient following the termination of his analysis. In addition, the patient's symptoms and life style were extremely unusual and interesting. Therefore, the case is worth reporting on its own merits.

I wish to raise a number of questions concerning what happens after an analysis. Is there a post-termination phase of analysis which should be recognized as a distinct entity with ceratin regular characteristics? If there is a post-termination phase, how can we best study it? Should we rely on haphazard and accidental followup reports of analytic cases, or are we justified in contacting former analytic patients to obtain information on the postanalytic period, and on the patient's further development?

CLINICAL MATERIAL

The patient began analysis when he was thirty-seven years of age. He had been married for twelve years, but had never had sexual intercourse with his wife or with any other woman. He was moderately successful in his career, although he suffered from work inhibitions which paralleled his sexual inhibitions. He was an obsessive-compulsive character who led a rigid, restricted life, although, paradoxically, he was freethinking, and vicariously enjoyed the instinctual life of others. His major motivation for analysis was to overcome his sexual problem. His depressive moods never represented a major problem.

His wife was also a virgin. Through the years of their marriage and previously, during their courtship, they indulged in occasional

petting and mutual masturbation. From time to time they discussed their sexual abstinence, but neither was able to take definitive steps to correct the situation.

The patient was an only child of a Fundamentalist Protestant family. He grew up on a small farm where he witnessed his father and grandfather slaughtering animals. These memories, which formed the nucleus of his castration anxiety, were linked with fearful images of injury to his penis in his fantasies of coitus. He was overly dependent on his controlling and domineering mother, but had been able to break away from her during his college years. He remained inhibited in his behavior, thus obeying her religious and moralistic anti-sexual scruples, while at the same time his freethinking allowed him some measure of rebellion. He was influenced further by a family myth, according to which his mother was nearly killed during his birth due to extreme tearing and laceration of the birth canal. This myth was incorporated into his fantasies of destroying and damaging a woman during coitus. His wife was for him his mother reincarnate. He was dependent on her, did not touch her sexually, and was rebellious towards her by being a freethinker, taking dancing lessons, and entering analysis.

As the analysis progressed, the patient tried to initiate sexual relations with his wife, but she rebuffed him. He began dating other women and progressed to the point of petting with them after a prolonged period of talking, dancing, and kissing.

After two years of analysis the patient had acquired a good deal of insight into the childhood origins of his severe sexual inhibitions, and had accomplished a fair amount of working through. He was more determined than ever to lead a normal and active sexual life. He wanted to have children and was no longer satisfied with the dog at home which so clearly substituted for a child. His work as head of an adoption agency was also no longer satisfying. He wanted to go into the private practice of psychotherapy, hoping to become a man like his analyst.

At this point he announced his intention to achieve a major change in his life. He would have intercourse with his wife and a normal marriage, or he would get a divorce; and he would make an analogous change in his career and give up living vicariously.

However, he simultaneously announced that he wished to terminate his analysis. He felt he had to do it by himself, and not

give me ("mother") any credit for his growing up. He was also afraid that somehow I, like mother, would stop him. His castration anxiety in reference to his father was simultaneously mobilized. He was fearful to have sexual relations with a woman while still in analysis. I ("father") would slaughter him, as the farm animals had been slaughtered. We continued for several months to analyze the meaning of his strong need to bring about major changes in his life without help from me. In spite of persistent interpretations, he insisted on terminating the analysis prematurely. He indicated that he would return in the future if he was unable to accomplish his goals on his own.

AFTER THE ANALYSIS

Four months after his last analytic hour he sent me the following letter:

> I thought you'd like to know—more correct from my standpoint, I want you to know—that I'm in the process of getting a divorce; the transition from no sexual intercourse to current sexual intercourse was not so insurmountable as I thought; I'm planning to start part-time in private practice. Needless to say, I appreciate your help. Thank you very much.

Two and one half years after his analysis he sent me a printed Christmas card signed by himself, his new wife, and daughter. On the cover of the card was a picture of an old Joseph, a young Mary, and an infant child.

Four years after his analysis, I contacted the patient by mail. He had moved to another city and there had been no contact between us after the analysis except for the letter and Christmas card mentioned above. I asked him to fill me in on what had happened in his life since the analysis. I expressed an interest in his family, his work, and his feelings about the analysis. I shall quote several paragraphs from his letter, omitting identifying material.

> Things are going fine with me. I've remarried and have two little girls and a wonderful wife.
>
> I am director of a family service agency doing quite a bit of counseling; marital, parent-child, etc. Our second girl is almost a year old now. Family life is agreeing with me. Our relationship is solid

—my wife is direct which has helped me be more direct in verbalizing my feelings. Being close to my parents has intensified ties with which I am better able to deal although I'd have to say if I were in California the same things would not bother me half so much.

I have no doubt that the analysis helped me break away from my first wife; to see my relationship to my parents, especially my mother, and now to act rather than react to them; to express my feelings more openly; to feel more secure; to help families with whom I counsel; to be a more responsible husband and father. I don't mean to imply any drastic change in personality on my part but I do think a more healthy adjustment. Thank you for helping.

In this patient there seems to have been a clear and distinct "post-termination phase," during which time he worked through psychological problems and made changes in his life he did not, or could not make during the analysis proper. Perhaps this case illustrates in a magnified and exaggerated form post-termination changes which frequently occur in more subtle and covert ways.

DISCUSSION

The literature on the post-termination phase is relatively sparse. Rangell[10] described a period which he designates as the "Postanalytic Phase." Freud[3,4,5] reported followup material whenever it was available in a number of his classic case histories. The further developments of the Wolf Man, as reported by Brunswick[1] and by Gardiner,[6,7] have been invaluable contributions to psychoanalysis. Pfeffer[8,9] has contributed two excellent papers on the post-termination period. I am especially grateful to Eissler[2] for his report of a case in which profound and unsuspected changes occured in a patient only after the treatment had ended; the changes remained unknown to Eissler until he contacted the patient eight years after the termination.

I believe followup studies of our patients are important in understanding the analytic process and in evaluating the results of our work. Although some patients contact their former analyst following termination, others do not. Some of these patients could be invited back for one or more interviews, many years after the analysis, without causing them harm or intruding into their lives. In certain cases, a followup initiated by the analyst is contraindicated and should be avoided. The main factors to consider in initiating

followup studies are the transference and countertransference implications. Another source of research material for studying the post-termination phase can be found in the psychoanalytic clinics of our institutes. Over the past decades many patients have been analyzed at these clinics. Undoubtedly, they would cooperate in research projects designed to study developments in their lives subsequent to analysis. Perhaps fewer complications would occur if the studies were conducted by analysts other than those who treated the patients.

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THE TRAUMA OF EVENTLESSNESS

Robert Seidenberg

To fear the worst oft cures the worse.
Troilus and Cressida (III, 2)

The history of Freud's antinomy concerning the problem of anxiety is now well known, if not well understood. His early conceptualization divided the reaction of anxiety into two categories.[4,5,6] He described realistic fear, *Realangst*—the reaction of an organism to a real, external, apparently dangerous object or situation that mobilized the self-preservative forces of the individual. In this case, there might be an actual adversary, who would place life and limb in jeopardy. The organism is alerted hopefully with the response of fight or flight. As such, Freud felt that this reactive situation concerned the biologist or physiologist more than the psychologist. The latter would become preoccupied with the second type—namely, neurotic anxiety. For here there was no real, apparent, external danger yet the person reacted as though there had been.

Freud theorized that due to excessive repression, a "damming-up" of libido resulted. The pressure of this becoming intolerable, libido was, as Freud put it, discharged in the form of anxiety. It is not difficult to see the source of this conceptualization. In the early cases of hysteria, there were repeated instances of sexual "problems"; furthermore, anxiety states do closely imitate sexual excitement. There are other remarkable instances indicating the congruence of the two phenomena.[11,8] There is also the age-old, ineradicable myth that connects mental illness with "faulty" sexual practices, especially masturbation.

For several reasons, not the least being the "wildness" of interpretation that this theory lent itself to,[7] Freud came to modify his theory of anxiety, retaining nonetheless the duality for which, among many other things, he is famous.[8,9]

He saw that the distinction between real (external) and neurotic (internal) did not fit the facts. Abandoning the "spatial" configuration (external or internal), he constructed a "temporal" one. Anxiety now was a response to (1) present or (2) future danger or trauma. In the first instance, he spoke of the sudden accumulation of tension needs, possibly libidinal, that overwhelmed the organism, a reaction to a current trauma. The paradigm for this type is seen in infantile neurosis and later in life in the traumatic neurosis, a reaction to the unanticipated accident or assault.

The second category of anxiety, the main concern of this paper, is the reaction to future danger; it is an *anticipatory* phenomenon. Here the person responds in advance to real and imagined dangers or disasters to which he may be heir, from either personal or worldly relations. His advance worries may be needless, exaggerated, or quite appropriate, depending to a large extent on his own sensitivity. Their interpretation depends to some extent on the perceptiveness of the observer making the diagnosis. This anxiety is a preparation so that one will not be caught by surprise. Freud also stated that such episodes of anxiety were milder experiences of pain to desensitize the person, or perhaps to inoculate him against the greater dysphoria.

As Shakespeare tells us, "To fear the worst oft cures the worse." Although the expected catastrophe was generally thought to be, to a great degree, an internalized threat of the past, i.e., loss of love, castration, alienation, etc., Freud never did foreclose, but indeed herein recognized, the existential concerns about one's destiny that are inextricably tied to one's biological, social, and ecological situation and predicament—real and external dangers, be they apparent or not.

Many psychoanalysts did not follow Freud in his new modification. The revision of the theory that is generally accepted today is described by Waelder. The concern is not with realistic anxiety (relegated to other disciplines), but with the concept of neurotic anxiety. Waelder[18] writes:

> The revision of the theory of anxiety did not deal with realistic

> fear at all, only with neurotic anxiety, i.e., with anxiety in situations in which average people can either detect no danger at all or no danger great enough to justify the intensity of the worry. The person who is afraid of dogs, the adult woman who is afraid to walk down Park Avenue or Regent Street in broad daylight during the hours of heavy traffic, or the healthy young man who lives in constant terror lest he may come down with, or may already suffer from, a fatal disease, are cases in point; we then speak of neurotic anxiety because of its intensity, its refractoriness to ordinary explanations of fact and probability, and its omnipresence.
>
> It was with reference to neurotic anxiety only that the famous shift of view has taken place. In the case of the agoraphobic woman, for instance, who is likely to harbor rape fantasies, one would have assumed, according to the older theory, that her frustrated sexual desires had been transformed into anxiety, while the new viewpoint holds that she is afraid of her sexual desires and that this fear, always present, becomes greatly intensified in situations of opportunity and, hence, of temptation. In short, neurotic anxiety, i.e., anxiety without, or without sufficient, danger, has now come to be seen as basically similar to realistic fear, i.e., as a reaction to danger, albeit an inner one.

It seems that Freud's modification of his own theory went much further in ego psychology than Waelder's "extension." First of all, Freud broadened his view of need frustrations beyond the libidinal; Waelder's example of the agoraphobic woman stays within the narrow sexual one. Furthermore, Waelder's explanations are embarrassingly "linear"; the agoraphobic woman might possibly have other worries besides sexual ones. Similarly, the street may have a particular meaning to a woman who, say, had "worldly" ambitions.

The patient who is the subject of this article, a twenty-eight-year-old housewife, was perhaps, in the interpretation of the author, afraid of the street as representing "the world" from which she had been systematically and traditionally barred.

Waelder's psychoanalytic interpretation of agoraphobia oversimplifies the problem. While language origins are not to be used as ultimate definitions, it is nonetheless instructive to remember that the Greek word *agora* mainly referred to the popular political assemblage of a community. We also know that "proper" women were excluded from this public domain; courtesans were the only women seen in this environment. Today, the term *agoraphobia* connotes the fear of open spaces and is a symptom most commonly, although not

exclusively, found amongst women. One then is faced with the paradox of a woman who was originally prohibited by law and custom from entering "public areas" of activity, now diagnosed as *phobic* when she becomes anxious there!

It may be useful to examine the temptations in addition to sexual ones, even if the patient, as is often the case, expresses her agonies in the rhetoric of sex.

Today, a woman's desire for a public life is burdened by many frustrations as well as social and psychological penalties, in addition to gross inequalities of actual opportunity. Traditionally, hers has been the *private* sector; the *agora* was never a place where she was expected to be, or expected to feel comfortable. She is often faced with the dilemma of being a "private person" who is excited and stimulated by public affairs. As we know, the Greek word for "private person" is *idiotes,* from which we have derived *idiot.* (Identifying with such a word in itself might cause alarm.)

It is hoped that the aim of psychoanalysis is not to reduce its clients to the level of the average person's perception of what a dangerous situation is. Waelder's suggestion that a fear is "neurotic" because it is a response to a situation in "which average people can neither detect danger at all or no danger great enough to justify the intensity of the wrong" sets out low goals indeed for the psychoanalyst. Of course the issue is not whether the particular street is dangerous or not but the gestalt of the individual's life situation, its restrictiveness or autonomy, its oppressiveness or freedom. In this context a restriction of freedom, an impingement upon one's legitimate rights might be very worrisome to sensitive individuals and a matter of indifference to average people.

These are facts of contemporary life as well as the lessons of history. It is not only a fallacy but it betrays a naiveté (where it certainly should not exist) to say that because the *average* person does not *feel* external dangers, they do not exist. If the dangers are not external, as defined by the populace, they must, according to Waelder, be internal. And finally, Waelder's further proof that the anxiety must be "neurotic" because "of its intensity, its refractoriness to ordinary explanations of fact and probability, and its omnipotence" may betray the rigid thinking of the therapist more than the neurosis of the patient.

The author thinks that Freud's modification of his own previous

theory of anxiety is clinically more heuristic and more consonant with ego and existential psychological concepts than those revisions which Waelder describes as accepted by him and most psychoanalysts today. Particularly appealing is Freud's second premise of anxiety as a reaction to "anticipated" trauma, which Waelder could not accept. Two psychoanalytic theorists who fully share Freud's view are Schur and Rangell.[14,16] The latter writes of the reaction of anxiety: "It is *always* to a danger, which is *always* a traumatic situation, which is always present, *and* always anticipated. What is anticipated is always the worsening of the present lesser traumatic state." Freud saw that the libidinal frustration may at times be only a small part of the cause of the anxious response.

Of greater significance is the reaction of alarm to helplessness in determining the future course of one's life. This type of anxiety response might appear irrational to Waelder's "average" observer. Finally, Freud fully realized that the distinction between real (outer) and neurotic (inner) danger was untenable. There are indeed many real external dangers which are not apparent (sic) and one cannot assume that because such dangers are not perceived by the average person they are products solely of inner threats.

To demonstrate how helpful to this writer is Freud's modified theory, the following case is presented. The reader will note the evolving story of frustration and deprivation of human rights which characterized this woman's life. A person who might be described as having "absence d'espirit" proved to have the opposite. The reader may also contrast the interpretations herein given with the libidinal ones usually "assigned" to the anxious and agoraphobic patient.[1,12] Missing also is the reductionistic tendency of infinite regression, a concept which is growing in popularity as an explanation for human behavior.[15]

A CASE OF EXISTENTIAL AGORAPHOBIA

This protocol concerns a simple, timid twenty-eight-year-old housewife. She was referred to the author for psychotherapy by her family physician after she failed to respond to a variety of tranquilizers and other "psychotropic" drugs. Her presenting symtoms were fear of losing her mind, episodes of severe apprehension in the street and in stores, and fear that she might harm her three-year-old daughter. She was a plain-looking woman, uneducated, showing all the signs

of social bewilderment and ineptness. The writer was prepared for a session of questions—will I go insane, are there other people like me, is there any medicine for such things—all of these sad, repetitive queries of the bereft, underprivileged, and nonliterate.

The expectations of the therapist proved correct, but with an additional factor. The theory that she was beset with imaginary dangers stemming from drives and affects from within was only part of the story. She related that she was the elder of two children, having a brother five years younger than she. Her parents were immigrants from Eastern Europe, of the Russian-Orthodox religion. Her father had advanced to a semi-managerial position in a small paternalistic company. Her mother worked periodically to supplement the family income. The patient was brought up under strict discipline. She was a docile child and adolescent, having proper obedience and respect for her parents. Her father worried about her outside activities and fretted about some of her girl friends. He often followed her to school and met her on her return to see that she did not stray into corrupting circles of teenagers. Her social life was therefore restricted, but she managed to have some friends of both sexes. She never evidenced any rebelliousness.

After high school, no mention was made of further education although she had done fairly well in her courses. Instead, her father got her a job as a stenographer in the same company where he was employed. (Nepotism went along with the paternalism of this concern.) The father prided himself on being able to place his daughter in a secure setting, where he could keep an eye on her. She was not consulted as to where she would like to work, or at what; it was assumed that any girl would be grateful for such a job.

At her job, again through her father, she was introduced to a young college student who worked there during the summer while preparing to become an engineer. This was thought of as a fine match by her father, who did everything to encourage the relationship. The French say: "Marie ton fils quand tu voudras, mais ta fille quand tu pourras." (Marry your son when you will, but your daughter when you can.) The young man completed college and they were married; he returned to this same company as a full-time employee. After her marriage, she left her job. A daughter was born soon thereafter. The external circumstances of her life appeared ideal—she had

a husband who was good to her and who had a bright future, satisfied parents, a nice home, and a healthy baby.

Concurrently her younger brother was approaching manhood. The course of his life, however, contrasted sharply with hers. An inferior student in high school, he was nonetheless encouraged to go to college. He was fully supported financially, and even given a car when transportation became a problem. With some continuing academic difficulties, he completed college and was immediately hired by an architectural firm at a good starting salary. There was no suggestion that he join the father's company, which was thought to give inadequate opportunity for his talents.

Three years after the birth of her daughter, the patient responded to her seemingly ideal external conditions with the symptoms mentioned above. This was a puzzle to everyone and a source of rage to her father, who did not want his daughter to be a burden to his son-in-law. The patient found no friendly listener amongst her relatives —they interpreted her sadness and fearfulness as signs of selfishness and ingratitude. "Doesn't she have everything? What more does she want?" Yet she was beset with attacks of anxiety.

"I'm afraid something is going to happen but I don't know what it is." As her life story unfolded, it became apparent that her timidity and docility had naturally deprived her of adventuresomeness, choice-making, and even minimal self-determination. She had not become pregnant out-of-wedlock, as her father feared she might. Her present and her future were reasonably assured.

What had she to fear? She was well adjusted, accepted by her friends and family, loved by her husband, fulfilled as a woman and mother—there were certainly no external dangers—she had probably more security than the average person. Internal dangers, of course, might include fear of sexual feelings, long repressed or contaminated by earlier parental threats and warnings. Then there was fear of harming her daughter, an obsessive thought that might too readily be interpreted as sadistic in quality. Clearly, her anxiety could be interpreted as a reaction to danger from within—deductively there being none from without.

However, the hypothesis that proved to be more logical and heuristic was Freud's statement of anxiety, as a response of anticipation to future dangers *which were as much outside of herself as*

within her. This encompassed her life style which would be set for the next thirty or forty years—one in which she would continue to be dutiful and obedient, now to her husband instead of to parents, and one in which there would appear neither choices nor challenges—an uninterrupted continuation of the first twenty years of her life. We soon became aware that in her apprehensive exclamation "something is going to happen, but I don't know what it is," she was secretly lamenting the danger that the *opposite* would be true, that in her life "nothing would happen"! She had been caught in a secure trap with the courage neither to complain directly nor to extricate herself. Her life at home and in the streets and in the stores was devoid of deprivation, predatory human beings, or ferocious animals! The absence of challenge, of decision-making, of problem-solving would instead be her destiny. Even her daughter at the age of three appeared self-sufficient, engaging only a small part of her time and attention.

A trauma, in psychoanalysis, generally has been difficult to define. Broadly speaking, it is thought to be "a startling experience, a shock, with lasting effects." The *Glossary of Psychoanalytic Terms and Concepts*[13] published by the American Psychoanalytic Association defines trauma as follows:

> A stimulus, arising from an external situation or from a massive inner sexual and aggressive excitement, which is experienced as overwhelming the ego's capacity to mediate between the various forces making demands on it. Such stimuli are usually sudden and disruptive, and produce a state of helplessness ranging from apathetic inactivity to emotional storm. Traumatic events are usually followed by marked regressive phenomena, severe inhibitions, and physical symptoms reflecting autonomic dysfunction.[13]

This traditionally held view of trauma, has as its chief distinguishing components a *stimuli* from without or within which overwhelms the ego leading to various symptoms and incapacitation of the person.

This writer contends that the very opposite—namely *the absence of stimuli*—can have the same effects. A lack of external events and appropriate internal responses can constitute a trauma no less than the "dramatic" assaults against the ego. More than that, the anticipation of more and more eventlessness may similarly constitute a danger of severe proportions to one's well-being. The case of the woman

under discussion is explained by this hypothesis. Her "breakdown" occurred at the point when she painfully realized that without some change or correction, her future life would be a continuum of a past which was characterized by submission to authority, absence of choice, and a general exclusion and isolation from the significant stimuli of life. Consistent with psychoanalytic theory, her anxiety contained the anticipatory repetition of the "traumas" of the past. Was she irrational in fearing that her future life would be as intellectually and emotionally constricted as her past?

The contrasting fate of her brother proved to be a precipitating factor in this woman's belated rebellion. This was no "neurotic" sibling rivalry but a realistic, objective appraisal of the inequities attending the raising of a son and daughter in a family of these socio-economic circumstances, where the son is held to be a dividend, the daughter a mortgage—as the ancient Greeks might tell us. Credit for intelligence, judgment, choice-making, and self-determination that was lavished on the son never was accorded the daughter. Not one to complain, she nonetheless felt the inequity and responded to it with her cryptic alarm and protest.

There are similarities between this life situation and that of Freud's "Dora," of whom Erikson writes:[2] "Dora needed to act as she did not only to vent the childish rage of one victimized but also in order to set straight the historical *past so that she could envisage a sexual and social future of her choice*" (italics added). And Erikson finds the turning of the father away from the daughter to the son as the crucial wound; "a vital identity fragment of her young life was that of the *woman intellectual* which had been discouraged by her father's delight in her previous intelligence, but discouraged by her brother's superior example as favored by the times. . . . The negative identity of the 'déclassée' woman (so prominent in her era), she tried to ward off with her sickness. . . ."

Although the woman in this protocol had none of Dora's intellectual pretensions, the fall from importance and significance in the family was quite similar. The contrasting destinies of brother and sister in each instance became crucial in determining the attitude of pessimism and hopelessness of the overlooked ones. Apparently for Dora and this woman their struggle for equality and their sense of injustice foredoomed a graceful acquiescence to a role of passivity and (for them) inferiority.

Similarly her untoward thoughts about her daughter originated not so much from pent-up sexualized or deneutralized aggression,[10] but as a component of the chagrin over the fate of the female. Was her daughter to be destroyed as she thought herself to be? Would destiny impel her to foist upon her daughter the inequities she herself felt?

These are *real* dangers and they are *external* but may not be apparent except to the observer who has thought about them. One is not justified in declaring these dangers either unreal or internal because they are not universally perceived or acknowledged. Often the therapist is still listening with the "third" ear when the times call for a fourth.

The course of psychotherapy was in large measure predictable. For a long period, she both affirmed and disclaimed her boredom, her dissatisfaction and her own insignificance. She asked the questions put to her by her husband, her parents, and her own superego —to wit—why her? Why was everyone else in her circumstances contented with their lives? No one else had to go to a doctor! And when would she stop going? Was she really indulging herself in receiving a "talking" treatment? And was she in truth going through an infatuation with the doctor when she should have her mind on her family and household chores?

The area of greatest suspicion was the absence of medication in the therapy. There are now miracle drugs that bring contentment. The doctor seemed to be agitating rather than relieving. The husband began contemplating what might happen to the marriage. Yet with new insights she began observing and noting that all was not so tranquil with others "in her circumstances." It became a source of pride for her to recognize new aspects of living and forces that were acting on her and others. Her husband, predictably, felt that she must "change her attitude" and then all would be well. In this, there was inordinate pressure for chemical tranquilization so that she would no longer be a disrupting factor. When she finally became aware of her legitimate struggle against "disappearance," her physical symptoms largely abated and her energies were channeled into areas that might change her plight. This eventually was encouraging to the husband who earlier in the "illness" had felt he was at the end of his rope in dealing with her, and had wondered whether or not she should be hospitalized.

Was her past disturbing? Yes. In her early years her parents were in the throes of elevating themselves from the poverty level of existence. Both parents worked hard, and there was always anxiety lest the fragile progress be impeded. The children had to be well disciplined and separated from the temptations and exposures that bring social disaster to all. The father was a hard and determined worker, never departing from the proper behavior and decorum his boss demanded. At times it was touch-and-go but gradually he became a member of the team and felt a modicum of security. Overhanging his existence, however, was his lack of formal education; he felt the pressure of the new employees, now almost entirely college-trained. Here he was confronted with his ambivalence toward education. On the one hand determined that his own son receive "the best education possible," he was conscious of his own deficiencies and inadequacies vis-à-vis the upcoming young men "who could write a decent letter when they had to." Yet if he reluctantly and painfully saw the necessity of education for his son, his pride could not allow his daughter to have more education than he. In this time of life, as if learning from Lear, he would not have a daughter lording it over him. His frustrations were unevenly distributed, landing on the female, as typifies worldly priorities. For him, a girl was a success if she caused no trouble or disgrace, as well a girl might through "becoming a bum" or getting pregnant out-of-wedlock. He had heard that girls who go off to college are apt to "go wild," losing respect for parents and bringing shame to the family name. It would not do for the son to have a sister who was a "tramp." Elevation to the middle class had come hard enough, no need for experimentation.

She became "daddy's girl" and frequently was the only one in the family who could talk back to him, but only in inconsequential areas. She was very solicitous of her brother and sought to protect him from the wrath of their father on the infrequent occasions of his rebelliousness. Toward her mother she was similarly solicitous, but felt neither awe nor affection. It was the father who appeared as the ultimate figure of authority who would determine her destiny.

In her teens the sexual threat, the specter of "going wrong," was constant and made sex loathsome, mysterious, and intriguing. Her one great power was to undo; her father made her aware of this. At times his very preoccupation with sex appeared to her as a com-

mand. She related that she felt that he was almost disappointed that she was not adventuresome in this area. Sexual adjustment in marriage, after the initial shock, was satisfactory to both partners and remained that way.

Similarly, her "object relationships" by all conventional standards were adequate. The family, particularly the father, breathed a sigh of relief; the ordeal of carrying a daughter through the pitfalls of adolescence ended in success. That the father's preoccupation was a manifestation of the *repressed sexual problem of fathers and daughters* is a given but the augmentation wrought by social pressures as well as class prejudices were determining factors in his attitude and behavior. Her obeisance was more apparent than real. Unexpectedly, she became aware that she was paying too high a price for the needs, real or fancied, of others. Her neurosis, developing as it did, was her rebellion. She was not "spoiled by success" as some would say. Instead she sought to save herself from complete annihilation by a self-preserving negativism, a refusal to become the possession and vassal of still another man (her husband) who would take her for granted. She could not, with her training and timidity, become a "bad woman" to show her protest. What was left to her was more of the same, to exaggerate her timidity to a fault, literally to become afraid of her own shadow (how much more feminine and passive can one get?).

In all, the dilemma of this woman was summed up in a statement which came in the context of a request for an assessment of her own struggle: "I don't want to be forgotten."

Attuned as we are to the threats of untoward nefarious drives from within, and catastrophic events from without, we may forget the despair that comes from the prospect of a passionless and unchallenging existence. The trauma *of nothing at all ever happening,* of eventlessness as far as involvement or engagement are concerned, can be a catastrophe of major proportions. Although the patient described probably never heard of him, Thomas Carlyle observed: "The tragedy of life is not so much what men suffer, but rather what they miss."

Stein,[17] in an eassay entitled "Fear of Death and Neurosis," points out that the anticipation of one's death, the knowledge of the ultimate biological defeat to which all the living are heir, is an intrinsic part of the neurotic and psychotic process which has not re-

ceived adequate emphasis in psychoanalysis. He writes: "Whereas neurotic anxiety contains anticipatory repetition of the biotraumas of the past, the affective state of depression, which originates in the separation from the object, seems to be maintained by the anticipation of the future inevitable loss of self." Stein's reminder is a welcome one in that it points in the direction of man's concern about his existence, but his conceptualization falls short of dealing with problems of existence which are not primarily biological but perhaps are more relevant to identity, sense of worth, and personal goals.

Deaths can be many, the biological is but one. People worry about their survival: professional, social, and political, as well as biological. It has been this writer's professional experience that loss of self encompasses matters of quality of living, accomplishments or the lack of them, meeting or falling short of one's ego-ideals, and, to be sure, success in object relations. Failure at these are as relevant and crucial in fostering hopelessness as the knowledge of one's inevitable demise. We hold with Kierkegaard that we are always well aware of the loss of a limb, a wife, or a five dollar bill. However, the loss of self in its many subtle manifestations and forms is not well understood. The self slips away and only the fortunate get a warning signal.

In the case of this woman, one gained the insight that she was anticipating, or perhaps reporting, her own social and psychological "death." Luckily, she was anxious about her destiny and cried out against what might seem its inevitability. Her anxiety was salutary and self-preservative; she would "not go gentle into that good night."

This woman's symptoms allowed her to separate herself from the fate of the young women with whom she grew up and who now surrounded her in the suburbs. In the other world, she withdrew from the role of shopper and hair-dryer captive. In her home, she held her ground in having but one child, no small feat in light of the persistent pressures of husband (don't you love me?), relatives, friends, and the church. If not for having children, why women?

Limited by lack of education and worldly experience, her positive accomplishments were modest. She was able to work part-time as a door-to-door canvasser for a research corporation. This was surely not world-shaking but nonetheless puzzling and dismaying to her relatives who deemed such work dangerous for a woman, especially since it brought her into "inner city" districts. Plagued by

anxiety in supermarkets and beauty salons, she suffered no fear in this "outside" work, only exhilaration, giving evidence once again that the overriding danger to her existence lay in the "safety" of the housewife's role. The hostile elements of her environment were not the people of the street but her "loved" ones who saw her as pure biology.

Therapy encouraged the *actualization* of her worldly aspirations. A woman's destiny might indeed be broadened. As a result she began to feel human and rational. Until then in her milieu she had been perceived as insane at best, misanthropic at worst. Incidentally, there was a fortuitous assist from the fast moving events of the world, to wit, with the new urgency for population control, her insistence on not having more children now appeared as not entirely nonsensical and selfish to some around her.

SUMMARY

Freud's modification of his earlier theory of anxiety in which the temporal (anticipatory) dimension is emphasized proved heuristic in explaining the problem of a young married woman who sought therapy. In her life-situation, it was the anticipation of "more of the same obscurity" that proved to be the frightening factor.

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FREUD AND THE MYTH OF BRITISH CITIZENSHIP

William Ruff and
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Ernest Jones once wrote of Freud and the stories invented about him: "The mythopoeic faculty of the surrounding world, always so busy with Freud's personality—it has certainly not ceased with his death—pursued him to London."[3] One popular myth, or improbable story, asserts that Freud died a British citizen. In 1947, Helen Walker Puner,[4] in *Freud, His Life and His Mind* wrote, "The government put an official stamp on his welcome by granting him British nationality"; and in 1952, Rachel Baker in *Sigmund Freud*[1] said, "The British government granted him honorary citizenship." As recently as 1965 we again come upon this "fact," this time with some embellishment by the eminent historian A. J. P. Taylor, in his *English History 1914-1945,* Volume 15 of the Oxford History of England.[5] Professor Taylor states: "After the incorporation of Austria into Germany, Sigmund Freud, founder of psychoanalysis, was admitted into England with none of the usual formalities, and, against all the rules, was made a British citizen the next day." A note reads, "Legally, naturalization was granted at the unfettered discretion of the home secretary. The invariable practice was to require five years residence and evidence of good character."

However, Ernest Jones[3] gives a different account in his definitive *Life and Work of Sigmund Freud:* "One great wish of Freud's was destined never to be gratified: to die a naturalized British subject. Commander Locker-Lampson raised the question in the House of Commons, but the Government refused to shorten the normal waiting period, presumably lest it set a troublesome precedent."

The contradiction in these two accounts is perfectly clear. Ernest Jones says that Freud did not become a British citizen; Professor Taylor says that he did become a British citizen, and that within twenty-four hours of his arrival in England (that is, on June 7, 1938). But Professor Taylor is certainly wrong in saying that citizenship was granted Freud by that date, for on July 16, 1939, Freud was writing to H. G. Wells:[2]

> Your letter starts with the question of how I am. My answer is I am not too well, but I am glad of the chance to see you and the Baroness [Moura von Budberg] again and happy to learn that you are intending a great satisfaction for me. Indeed, you cannot have known that since I first came over to England as a boy of eighteen years, it became an intense wish phantasy of mine to settle in this country and become an Englishman. Two of my half brothers had done so fifteen years before.
>
> But an infantile phantasy needs a bit of examination before it can be admitted to reality. Now my condition is the following: There are two judgments on my case: one of them represented by my physicians maintains the hope that the combined radium and X-ray treatment I am now undergoing will cure me of the last attack of my malignant growth and leave me free to meet other adventures in life. Perhaps they only say so officially. There is another party much less hopeful to which I myself adhere in view of my actual pains and troubles. Now let us suppose the fact that you know the affair of the Act of Parliament cannot go through before half a year or more. In such a case, I expect you would prefer to drop your intention. So I have an interest not only in seeing you but also in your seeing me.

"The great satisfaction" mentioned in the letter above refers to the fact that, "Wells intended asking Commander Locker-Lampson, M.P., to introduce an Act of Parliament conferring immediate British citizenship on Freud."[2]

We may accept the fact that Freud was not given citizenship within twenty-four hours of his arrival in England; but may it not have been granted between July 16, 1939, and September 23, 1939, when he died? All the evidence we have found rejects this idea. Ernest Jones, who knew Freud intimately, denies the fact; Freud is not mentioned in any supplement to the *Dictionary of National Biography;* no *Who's Who* mentions citizenship; there are no re-

ferences to it in Ernest Jones's obituary, or in any obituary which we have read; neither the *Official Index to the Times,* nor the *Index to the New York Times* refers to such a grant; there is nothing in *Commons Reports* for this period. We have checked Professor Taylor's references and find no documented statement concerning citizenship.

We may conclude that the story of Freud's British citizenship is a myth. The real mystery is the source of the misinformation and why so careful an historian as A. J. P. Taylor should repeat the story as late as 1965. It appears that the "intense wish phantasy" of Freud to become a British citizen has indeed been "admitted to reality," albeit to the mythic "reality" which envelops great persons.

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AN INFORMATION-PROCESSING MODEL OF FREUD'S CONCEPT OF CATHEXIS

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Freud's psychoanalytic theory contains four distinct models: the reflex-arc model, the entropy model, the Darwinian model, and the Jacksonian model.[3] Freud utilized those models which were prevalent in the more important areas of learning in his lifetime. The reflex-arc model and the Jacksonian model of a neural integration hierarchy were powerful explanatory constructs for the physiologist and the neurologist. The notion of entropy enabled the physicist to account for many of the thermodynamic phenomena. And naturally, the Darwinian model gave a new perspective to the biologist and the paleontologist.

Since Freud adopted the latest models when applicable, it seemed highly probable to this writer that if an information processing model were readily available to him, he would have employed it in an explanatory capacity. The task this writer set before himself was one of incorporating an information processing model with Freud's notion of cathexis. Taking Rapaport's suggestion that a full description of any psychological phenomenon must include its dynamic, topographic and economic descriptions, this writer attempted to include these various descriptive levels of analysis in a model of cathexis. As a preface to the model, a brief review of some of the relevant literature dealing with cathexis will be presented.

CATHEXIS: A SUMMATION OF SOME OF THE LITERATURE

Colby[1] discussed cathexis within a dynamic framework. He asserted

* At the time of the writing of this manuscript the author was a NDEA Title IV Fellow. The views expressed are those of the author and do not necessarily reflect those of the Department of Defense or the Air Force.

that cathectic energy (CE) is a postulated form in addition to known mechanical, thermal, electrical, and chemical energies. With the proper physical units, CE could be transformed into the units of the other forms of energy. It appeared doubtful that the laws of thermodynamics, the law of the conservation of energy and the law of entropy could be correctly applied to any energy process in a living organism. An organism is not a closed or isolated system. It constantly takes in and puts out energy in various forms. Also, an equilibrium requires no expenditure of energy for its maintenance, while an organism does.

Freud considered instinct or drive as a force consisting of internal excitatory stimuli arising from the body, impinging on the psychic apparatus, and consequently, impelling the organism to specific actions. CE was thought of as a quantum of energy capable of effecting goal-striving behaviors. Colby speculated that

> . . . this assumption brings difficulties into formulating a logically consistent energy theory, since all other forms of pure energy, as we know them, have no aims. Energy alone simply dissipates. Only energies operating in some organized structure achieve goals. In the case of organisms, a goal is an end-product of multiple factors, a final decision of the governing apparatus responding to a legion of stimuli. . . . To believe that instinct as a CE sum possesses an aim is fallacious, since no energy can have an aim.[1a]

The psychic apparatus (PA) was a hypothetical construct which represented the organization of nervous system functions. The PA was not isomorphic to the brain, but it was influenced by conditions within the environment, within the organism and, most markedly, within itself. The means of influence from these three sources was conceived of in terms of quanta, or stimuli. Quanta from the external world, from the interior of the organism, and from the PA itself aroused activity in the PA, which, in turn, directed energies back to these sources. Colby attributed to the PA three functions—perception, registration, and action. Perception involved processes and selection and exclusion of stimuli, registration concerned the recording and storing of experience, and action resulted from the directed output of stimuli to the body. The PA was conceived of as an organizing, transforming, integrating agency with an energy supply independent of incoming quanta. Incoming stimuli only triggered

off processes within the PA whose energy set off other energy in a chainlike way.

Like all representations in the PA, drive schemas were also invested with CE of their own which was influenced by physiological signals from incoming stimuli. Having been excited by these quanta, drive schemas in turn excited other parts of the PA with their specific content in order to goad the organism into action. Drive schemas in turn varied in their activity as a function of CE. The CE construct served to describe the activity, not content, of drive schemas; CE alone cannot account for drive function without the aid of structural constructs.

Freud[2] described cathexis from topographic and economic points of view. He proposed that the work of the PA was regulated by the effort to avoid accumulation of excitation and, as far as possible, to maintain itself free from excitation. For this reason it was modeled after a reflex apparatus; motility was the channel of discharge at its disposal. The accumulation of excitation was experienced as pain which set the PA in operation in order to reinstate gratification; the diminution of excitation was perceived as pleasure. Such a current in the PA was called a wish; nothing but a wish was capable of setting the PA in motion. The first occurrence of wishing might have taken the form of a hallucinatory cathexis of the memory of gratification. This hallucination, unless it could have been maintained to the point of exhaustion, might have proven incapable of securing pleasure connected with gratification. Consequently, there was a requirement for a second system that would not allow the hallucinatory cathexis to force its way into perception binding psychic forces. The real perception of the gratifying object was imperative for satisfaction. This second system required full command over all memory-material. Otherwise, there might be superfluous expenditure of CE which would then flow away to no aim, diminishing the quantity needed for adaptation. The pain principle also acts as a regulator of excitation in the second system. Freud postulated:[2a]

> . . . that the second system succeeds in maintaining the greater part of the energic cathexes in a state of rest, and in using only a small portion for its operations of displacement. The mechanics of these processes is entirely unknown to me. . . . I do no more than hold fast to the idea that the activity of the first system aims at the

> "free outflow" of the quantities of excitation, and that the second system, by means of the cathexes emanating from it, effects an "inhibition" of this outflow, a transformation into dormant cathexis, probably with a rise of potential. . . . After the second system has completed its work of experimental thought, it removes the inhibition and damming up of the excitations and allows them to flow off into motility.

From a genetic approach there is a flow of CE from object to object, and from one mode of gratification to another during the course of psychosexual development. Freud assumed that the libido which cathected an object or mode of gratification of an earlier phase gradually became detached from it. Instead, it cathected an object or mode of the next phase. However, no strong primary cathexis was ever completely abandoned. Most of the CE might flow on to another object. Normally, some remained bound to the original one. The persistence of CE in an object of infancy or childhood into later life was called fixation. Fixation was usually wholly or partly unconscious; there was no relation between the strength of a fixation and its accessibility to consciousness.

PREFACE TO THE MODEL

The above literature was presented here with the intention of substantiating this writer's thesis that Colby, Freud, and Rapaport either expressed or implied the existence of some sort of information network or system which controls or guides the distribution of CE. Colby affirmed that an organism cannot properly be considered as a closed system. It continually receives various energy inputs and transduces these into multi-behavioral outputs. He also alleged that CE just spontaneously dissipates. Only CE which is operating in a psychic structural apparatus can be goal-directed. The PA operates on stimuli from the external world, from the interior of the organism and from the PA itself. It in turn directs CE back to these sources. As they are stimulated by these inputs, drive schemas excite other components of the PA with their content. Colby stated:[1b]

> When structural systems (Cs., Pcs., Ucs.) operate they are assumed to transmit information in the form of messages and to have varying degrees of activity. To conceptualize the energic form of messages and variations in activity we utilize the energy construct or cathexis.

On a primary level the PA is automatically regulated by the perception of pleasure and pain. On a secondary level the PA is inhibited by the Pcs. which has a large number of accumulated experiences in its memory. After processing the experiential data that it has in storage, the Pcs. may release CE that it has inhibited. This secondary system frees CE only if it predicts on the basis of the information at its disposal that no pain is involved. The Pcs. monitors the distribution of CE by integrating sensory input. The PA must process information in order to effectively accomplish the vital psychic functions.

> Perception (P) through our sense organs results in directing an attention-cathexis to the paths along which the incoming sensory excitation of the P-system serves the mobile quantity in the psychic apparatus as a regulator of its discharge. We may claim the same function for the overlying sense organ of the Cs. system. By perceiving new qualities, it furnishes a new contribution for the guidance and suitable distribution of the mobile cathexis-quantities. . . . It is probable that the pain-principle first of all regulates the displacement of cathexis automatically; but it is quite possible that consciousness contributes a second and more subtle regulation of these qualities, which may even oppose the first, and perfect the functional capacity of the apparatus, by placing it in a position contrary to its original design, subjecting even that which induces pain to cathexis and to its elaboration. . . . An important part in the functional activity of the apparatus is ascribed to these regulations by the qualitative excitations of the sense organs.[2b]

Rapaport emphasized that behavioral energy is controlled by psychic energy acting through a structural system which releases energy according to the dynamics and economics of psychic forces. He alluded to:

> mobilization, on the one hand, as the weakening of controls defenses, and on the other as the libidinization of structures or functions. This motor energy of behavior is controlled or released by the economics of psychological energies and by the corresponding dynamics of psychological forces which operate through psychological structures. It might be suggested that this relationship is akin to the control of large amounts of energy (muscular) by an information network operating with smaller amounts of energy (psychological).[3a]

Since neither Colby, Freud, nor Rapaport presented an actual information processing model to describe the various control mechanisms of CE, this writer will now present a model which will adequately and parsimoniously account for the factors regulating the release of CE. While attempting to do this, he desires to remain congruent with the aforementioned theory of cathexis by explaining salient psychoanalytic concepts in terms of this model.

THE MODEL

The applications of communication theory and computer models to psychology have greatly stimulated thought in this area. Their constructs have contributed much to the analysis of human behavior. A person can be regarded as a kind of transducer in a communication system—as a receiver of power input from two systems (the internal and external environments) and as a supplier of power output to different systems (the somatic and autonomic nervous systems). An individual then can be considered as receiving information from his surrounding world (perceiving), storing it (memorizing), and transmitting it (communicating).

This writer believes that Freud's psychic apparatus can be considered as a communication system with computer-like components. It will be shown that the PA is a competent transducer, having two essential functions—gathering information from both the environment and past experience, and monitoring psychic energy distribution.

The functional components of this system are as follows:

Read-in Unit (Cs.)

This component receives input data from external sources and the external motoric transducer. All novel external data must pass through this system; that is the means by which the PA acquires external information.

Decoder

This unit translates the messages received by the read-in unit into comparable psychic-apparatus language. It is one of five components of the computing system.

Interpreter

It is the second component of the computing system, which reads the PA-language for the computing system.

Arithmetic Unit

The third component of the computing system, which performs numerical operations on what the interpreter reads and what is retrieved from storage; it performs these operations according to a stored program.

Control-Generator Unit

The fourth component of the computing system, which governs the output unit; it monitors CE distribution according to the arithmetic unit's dictates.

Accumulator-Register Unit

The fifth component of the computing system, which serves as readily accessible temporary storage for the arithmetic unit; it makes difficult computation possible.

Computing System (Pcs.)

The calculating system of the psychic apparatus, composed of the interpreter, the arithmetic unit, the control-generator unit, the accumulator-register unit, and the decoder; it receives input from the read-in unit and monitors the content of memory-storage.

Output Unit

It selects the means of output according to the control-generator's dictates; it governs the motor unit; and it puts data into storage.

Motoric Unit

It monitors behavior by controlling the internal environment (autonomic nervous system) and the organism's behavior toward the external environment (the somatic nervous system).

Memory-Storage Unit (Ucs.)

This system permanently accumulates all input data to the PA, whether it by-passes the computing system or not. Data which is retained only temporarily in the accumulator-register can be held in memory storage on a permanent basis. This storage unit can directly control the output unit without mediation by the computing system. Finally, this memory-storage unit contains the feedback-data program which has been psychically determined by all data entering the PA.

Input

The input consists of "enco-info" messages composed of data. Each datum that enters the computer-like PA is assumed to be resolvable into two components. One component is the energy element, and the other is the information element. The energy element is measured in terms of CE units; the information element is measured in terms of bits. The amount of primary information in bits is given by:[4]

$$\Sigma\ p_i \log_2 p_i$$

where p_i is the expected subjective probability of a particular datum to reduce tension based upon past utility. p_i is a function of the number of possible alternate pieces of data that the Ucs. has in storage which it considers in regard to reducing a particular pain or increasing a particular pleasure. The amount of secondary information is given by:

$$\Sigma\ q_i \log_2 q_i$$

where q_i is the present subjective probability that a particular datum will reduce tension. q_i differs essentially from p_i in that q_i is a more "objective" estimate of the probability than p_i because it has just entered the PA. q_i is the probability based upon present "perception," whereas p_i has been stored in the Ucs. for some time interval. While in memory-storage, p_i does not remain constant but changes as a function of time. As the PA processes more and more data, the process of maturation, the number of possible alternates than can reduce a particular tension or satisfy a particular need normally increases. This process converts a q_i to a p_i which has been placed in permanent storage in the Ucs. by the control unit. A p_i is entirely determined by psychic experience, that is, q_i over time becomes some p_i. Some notable functional features of the operation of this computer-like transducer are to follow. If input is from a source external to the PA, not from the motoric unit, "enco-info" messages are read into the read-in unit, Cs. These messages are fed into the decoder, which translates them into PA-language. The messages are broken down into data, which are broken down by the recoder into CE units and bits. The output from the decoder is led into the interpreter which reads it for the arithmetic unit. The interpreter reads simultaneously the number of CE units and the number of bits. The output from the interpreter is fed into the accumulator-

register. The accumulator now reads the secondary information, $\Sigma\ q_i \log_2 q_i$ The program calls from a memory-storage address the corresponding primary information, $\Sigma\ p_i \log_2 p_i$, and puts it in the accumulator also.

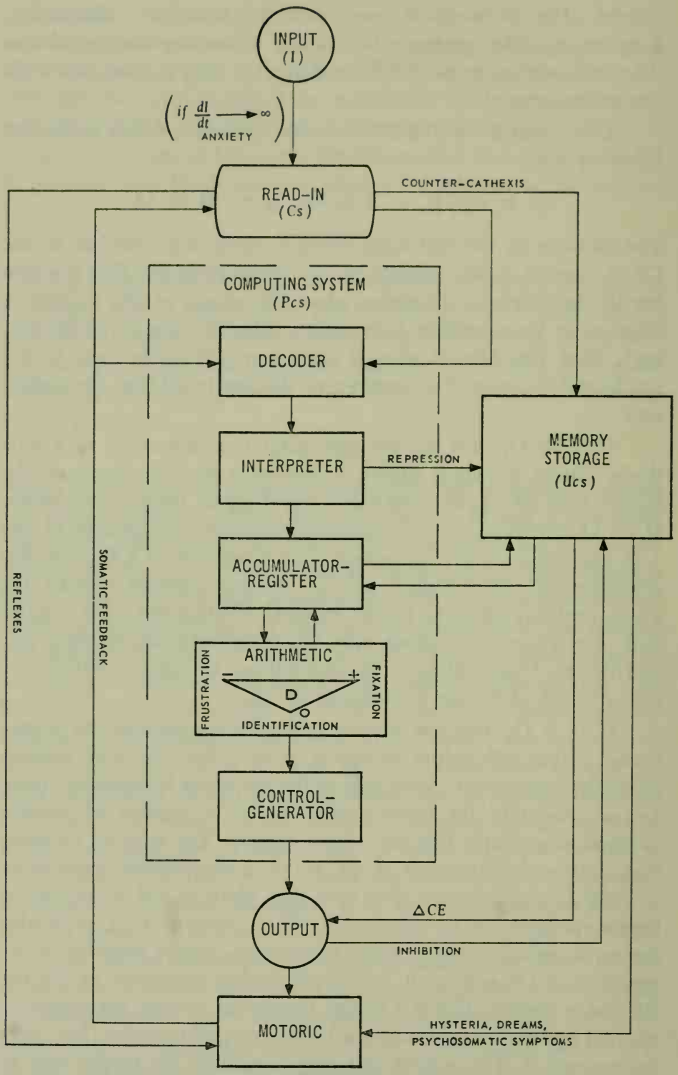
This brings the arithmetic unit into operation, which makes the following test:

$$\Sigma\ p_i \log_2 p_i - \Sigma\ q_i \log_2 q_i \stackrel{?}{=} D = O.$$

The outcome of this difference function determines whether or not CE is invested in the external source of the message. This function tests if the primary information about the source of the message is identical to the secondary information (identification or reality-testing). Note that identification is used here differently than in the psychoanalytic sense. The outcome of this test is fed into the control unit.

If $D = O$, then the expected subjective probability of a particular datum to reduce tension is identically equal to the more objective estimate of its probability based upon present perception. $D = O$ implies a perfect relationship between the contents of the Ucs. and the external environment. The investment of CE under this condition will either reduce pain or increase pleasure because the PA is perfectly adjusted to the external environment. The control unit now triggers the output unit, which activates the motoric unit and/or the Ucs., whichever is appropriate, to initiate suitable behavior acquired for the expenditure of CE.

If $D > O$, then the primary subjective expectation that a particular datum will reduce tension is greater than the more realistic secondary expectation. According to the secondary information, there are at present in the external environment a number of possible alternatives available that can reduce tension. The external information dictates a distribution of CE in all of the possible alternatives in order to maximize the likelihood that pleasure will be gained or tension avoided. If an amount of CE is invested in a particular datum according to the primary information, then a superfluous expenditure of CE will result, which will deplete the supply of CE the PA has in storage. This is a foolish investment because the objective, external probability approximated by the computing system, Pcs., does not warrant it. The control unit now commands the output unit to



FIGURE

A flow chart of the psychic apparatus which controls cathectic energy investment.

reduce the amount of CE the Ucs. has invested in that particular datum (inhibition). If the reduction does not take place and there is an overinvestment of CE by the Ucs. in a low-probability input alternative, then the Ucs.-storage system is malfunctioning by not utilizing control-feedback (fixation).

If $D < O$, then the more objective, secondary information dictates that a particular datum has a greater probability of reducing or increasing tension than that stored in the Ucs.-memory unit. The control unit now activates the output unit, which increases the amount of CE available to the motoric unit for its behavioral functions. If a sufficient amount of CE is not available to the output unit, then the control unit must transfer the required amount from Ucs.-storage. And if the memory-storage system does not have enough CE available to meet the present external demand due to investing in highly uncertain data areas, then the PA's function of reducing tension will be thwarted (frustration). If the required quanta of CE are available in storage and can be transferred to a lucrative, high-probability-of-returns area, e.g., inducing pleasure, then the PA can meet the demands of the input from the external environment (adjustment).

External input may take an alternate route to the one mentioned above—from the read-in unit (Cs.), through the computing system (Pcs.), to the storage unit (Ucs.), and then to the motoric unit. The input can entirely by-pass the computing unit and be shunted directly to the Ucs.-memory system. This makes it totally impossible for the computing system to calculate the difference test on the input data. There is no way the arithmetic unit can test reality if it does not have access to the data. Also, there is no difference function available to the control-generator unit. It cannot accurately control the output unit, which in turn cannot possibly govern the distribution of CE, not having any information available. Consequently, the computing system cannot monitor any CE-exchange with the external environment; it cannot energize any motoric output (countercathexis). CE cannot be distributed to an external datum of information, if the system monitoring the distribution of CE is not tuned in on the source. The CE-input shunted to the Ucs. is not available for the energization of behavior.

There is another shunt-route, again by-passing the computing unit, from the Ucs. directly to the motoric unit. When CE is ex-

pended along this path, there is no inhibition of the primary Ucs. system by the control unit. Under these conditions, CE is distributed solely according to pleasure-pain impulses. There is no consideration of the secondary information element of the stored datum. The motoric unit responds impulsively to the primarily unmonitored input it receives from the Ucs. This action results in irrational, overt behavior, and/or in somatic or autonomic symptoms, and/or dreams and wishes, e.g., hysteria, psychosomatic illness, or rapid eye movements. The motoric unit can also feed input data into the Pcs. beginning with the decoder or interpreter. The routes these data take are similar to those mentioned above for external input information. Hence, the Pcs. can monitor CE distribution in the motoric system by means of the pleasure-pain principle and the difference function test, e.g., somatic-autonomic feedback, taking care of physiological needs, instincts.

If the secondary information indicates to the interpreter that a transmitting source is certain to increase tension, then that datum is directly shunted from the interpreter to the memory storage unit. It is no longer processed by the Pcs. (repression). Affective discharge in the Pcs. system may create noise in the computing unit, causing it to malfunction. The Pcs. must then shunt the highly affective input to the Ucs. to maintain the integrity of the computing system. The essential function of the PA is to process information so it can regulate efficiently the expenditure of CE. If the rate of input of data is too rapid, the PA will be overloaded. Due to this rapid or random input, the PA will not be able to differentiate incoming messages (anxiety). Consequently, the system will not be able to function adequately.

Finally, the development of the PA is considered to be an increase in its capacity to process information. It is assumed that the capacity can be represented as a negatively accelerating exponential function of time approaching a positive asymptote. As the PA forms, it increases its input channel capacity, enabling the PA to scan a larger number of data at a much faster rate. This makes possible the variability in the distribution of CE which should accompany normal PA development. PA augmentation is paralleled by an increase in the storage capacity of the Ucs.-memory unit. The PA actually generates through the information that it processes, the probabilities required to relate effectively with its external and in-

ternal environments. It stores these acquired probabilities as a means for predicting future encounters with its environments so that it can energize those behaviors which have a high probability of producing pleasure and avoiding pain.

The next phase in the development of this model consists in writing a computer program which will simulate the proposed PA. This writer is currently involved in producing a program that will mimic the PA well enough to permit actual testing of the model. The results of this endeavor are pending.

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THE JIGSAW OF AN OEDIPAL CONFLICT

Adolf G. Woltmann

How successful is a "successful" analysis? Do analysts usually succeed in reaching the deepest layer of a patient's unconscious?

The following material deals with problems that first arose in 1940. It was not till nearly thirty years later that all of the pieces, unearthed in two analyses, formed a meaningful, clear and coherent composition and fell into place like a finished jigsaw puzzle.

In order to trace the unfolding of the conflict and reaching its final dimensions, I am using my own analytic pilgrimage as an object for demonstration. Something remained untouched. For a long time my own analytic training and knowledge did not provide the insight which I, while still an analysand, could not reach.

It has not been an easy decision to prepare these notes for publication because it takes courage to expose oneself. One hopes to be praised for such open-mindedness, but ridicule, rejection and perhaps even deadly silence could be in store for me.

Why have I chosen this thorny path of self-revelation? To the best of my knowledge I am free of exhibitionistic tendencies. I am not presenting this paper in order to gain recognition. I already have it. Sympathy? I am too old to be pitied.

This material is presented to show how my own experiences have taught me that even partial solutions are often sufficient for the "temporary" resolution of conflict.

Secondly, I thought that this presentation might be of help to students and practitioners of psychoanalysis in revealing some of the analytic processes. We speak of free association, transference, re-

sistances, repressions, and so on. How do these phenomena manifest themselves in analysis? My dual position as an analysand and as an analyst enables me to see these processes from both sides of the couch.

Last, but not least, I am aware of the fact that this kind of self-revelation has been done before. Sigmund Freud and Theodor Reik have revealed some of their innermost unconscious thoughts. Both men are respected for their frankness and their willingness to share. However, my following their example certainly does not elevate me into their company.

My first bout with Oedipal material occurred on May 14, 1940. I had been in analysis for four years with an American who had lived in Vienna and had been analyzed by Freud. During my analysis a number of important problems had been successfully clarified and modified, but probing into my Oedipal problems met with resistance. As far as I knew then, I had loving and accepting parents.

In the beginning of 1940, I had left the Children's Ward at Bellevue Psychiatric Hospital and joined a hospital team as a research psychologist. The members of the research team ate lunch in the doctors' dining room. On this particular day I sat down at a table with two young doctors. A few minutes later we were joined by a minister, our table being the only one where one chair was still empty. I knew this minister of Dutch extraction and he knew me. He had no parish of his own but gave spiritual comfort to hospital patients.

The minister was visibly upset. I thought amusingly that had he been a dragon, he surely would be breathing fire. My light mood was cut short abruptly. As he sat down opposite me and stared at me with eyes that looked wild and unsteady, he shouted, "All Germans are swine. You are a German. You are a swine." He kept on ranting about the Nazis having bombed and destroyed Rotterdam that very morning. He again looked at me and repeated in his sonorous voice that he considered me the scum of the earth because I had been born in Germany. I sat glued to my seat, tightly gripping knife and fork. Everybody in the dining room looked at our table.

This sudden attack made me speechless. Reason left me. Something welled up and completely engulfed me. I wanted to kill that man, run a knife through him and cut his throat. At the same time I became aware of another, equally strong force in me which

neutralized my murderous rage. The man insulting me was a minister who was addressed as "Father." My own father was a deeply religious man, a fundamentalist who never missed a church service. How could I kill a man who was called "Father"?

The next thing I knew was my being marched out of the dining room by the two doctors. They told me later that they had been very much afraid that I would commit an act of violence. I could not work that afternoon and went home. I called my analyst and got an appointment for nine o'clock that night. I spent the afternoon at home in a wild rage. I wanted to kill and, at the same time, something in me prevented me from taking action. I could not eat, but my wife told me later that I had managed to finish a pint of whisky. It did not have any effect on me. In looking back, I now believe that this is the closest I ever came to a psychotic break.

I don't know how I reached my analyst's office, but I got there. For the greater part of the hour the analyst sat and listened while I turned and twisted on the couch. I oscillated between shouting, screaming, babbling, crying, sobbing and whimpering. I was too deeply hurt to speak coherently. All the repressed anger towards my own father suddenly erupted like a volcano. Somehow the analyst managed to calm me.

During the months that followed I learned to understand that sometimes a son is justified in feeling anger towards his father. In analyzing the father—son relationship I learned to accept the fact that fathers are people too and therefore human. It was a bit more difficult for me to accept the fact that my father, due to his own inclinations, had also wanted to press me into a religious mold. I had successfully defied his efforts to make me study for the ministry, but felt that in some way he would get even with me. Part of me felt guilty. I had frustrated some of my father's fondest wishes. Therefore the insults heaped on me by a minister who was also called "Father" seemed to be punishment for having dared to oppose my father. I finally accepted the fact that the incident at the hospital had nothing to do with having opposed my father, but in the process of working this out I had settled a number of attitudes about the relationship to my father.

The first analysis was terminated in 1941. In 1942, I enlisted in the Armed Forces. I spent three years in uniform, twenty months of which I served overseas. After returning home in 1945, I toyed

with the idea of going back into analysis for several reasons. My younger brother had died of pneumonia in Germany at the end of the war. I had last seen him in 1930 during a visit there. We had been very close to each other, exchanging letters. I was keenly aware of the fact that I would never see him again. A second consideration had to do with the fact that life and its values take on an entirely different meaning when, while under fire, one may have only a few seconds to live. In becoming a civilian again I had to reorient all of my values.

But before I could find my way back to the couch, a nightmare occurred which overshadowed all these considerations. This nightmare and my reactions to it have been reported as follows on page 61 in Theodor Reik's book, *Curiosities of the Self*. I had told him about it while discussing experiences:

> I was ordered to Sing Sing to execute a condemned person. I see the condemned man. As I take a second look I see that my father is strapped in the electric chair. Next to him is a physician who nods his head in a friendly way, indicating that I should throw the switch in order to kill this man. The only thing I can remember is that my father looked at me with very sad eyes.
>
> I woke up with a start, felt hot and drenched with sweat. My heart was beating out of my mouth. I jumped out of bed and ran into the living room, opened the window, and sat by the open window for about an hour. The time was about four o'clock in the morning. I had a terrific case of tachycardia. I clutched my chest with both hands. I was sure that my heart would stop beating and I would die. After suffering great anxiety for about an hour, my heart slowed down to normal. However, I was afraid to go back to bed and sat in the chair next to the open window till daylight.
>
> The patient [myself], until this dream emerged, had never experienced a conscious death wish towards his father. It is essential for the interpretation of this dream that the excessive rapidity of the heart action in the patient described belongs to the latent dream content. It is as if he himself is the condemned man, thus both executioner and executed. ('I was sure that . . . I would die.') The unbearable anxiety also expresses this retaliation fear that torments him.

I could not think of going through another trauma like this and started analysis the same day with a young man of Canadian extraction, tall and about three and a half years younger than my-

self. I learned later in my analysis that I had picked him because in age and height he seemed to be a substitute for my dead brother. Added to this was the fact that he, like myself, was not a native born American.

I immediately recognized the death wish towards my father and the talion principle which caused me so much pain and suffering. I recognized the doctor in the dream but for some time could not understand why he appeared. It finally dawned on me that this man had been a pediatrician before the war. He was violently anti-analysis. During the war he took a three-month course in psychiatry and emerged as a "ninety day wonder" division psychiatrist. On his return to civilian life he gave up pediatrics and practiced psychiatry and psychoanalysis. I did not like him because I thought that he was "full of hot air." I could not take him seriously. It then occurred to me that I had entertained similar feelings towards my own father. I also thought of him as being insincere and hiding behind religious dogma. Both the analyst and I accepted this explanation. Neither one of us searched further to determine why an unfavorable opinion of one's father should result in such severe death wishes. During this successful analysis I was much more concerned with my dead brother and my relationship to my mother. Although the "death wish nightmare" had been instrumental in sending me back into analysis, it seemed to become less important as analysis went on.

During this time I became aware of a curious phenomenon. Although I have good command of both English and German, I suddenly could not remember the English counterpart for *wissen*. Each time I wanted to know I had to look it up in a dictionary (*wissen,* in English, means "knowledge.") I knew the English word "curious" but I could not think of the German word *neugierig*. I spent many hours on the couch trying to find out why I knew one German word and could not remember the English equivalent and could use an English word without remembering its German counterpart. I did not come to understand why I wanted to "know" in German but could not think of the same process in English and why I could be "curious" in English but completely inhibited impulses towards "wanting to know" (neugierig) in German.

In 1948, I was a panel participant at the annual meeting of the American Orthopsychiatric Association. The panel discussion had

to do with problems involved in training of psychologists as non-medical psychotherapists. Eight participants, including myself, were sitting on the dais. There were approximately eight hundred people in the large auditorium. Although I had lectured extensively before, I felt uneasy sitting there. I chided myself for having stage fright, because my paper was in front of me, neatly typed. If my anxiety persisted, I could read it. I became unduly tense as the panelist preceding me walked up to the lectern. Suddenly I saw at the wall opposite me, as if projected as a slide, something horizontal with black hair. I also saw a white thigh, a knee, and a calf bent at right angles. Like a flash I realized, "my parents, locked in intercourse." I felt as if lightning had struck me. I broke out in sweat all over. I wanted to shout and run but I couldn't. Eight hundred people were facing me and the doors were at the opposite side of the auditorium. When my turn came, I reached the lectern and delivered my paper. None of the people around me knew what I had just gone through.

I saw my analyst that night. He felt sympathetic about the circumstances under which this breakthrough had occurred. He also congratulated me for having finally reached the source of my Oedipus complex. I spent quite a number of sessions going over the material. I felt that I had reached rock bottom.

Years later I checked with my mother, with whom I always had a good and positive relationship. She confirmed the fact that, when I was not quite three years old, I had come into my parents' bedroom one morning while they were having intercourse. According to my mother's account, I began to cry when I saw her bed empty. She quickly appeared next to me, took me to bed with her and quieted me down. In an off-hand manner she mentioned that this happened while it was quite early, around four o'clock in the morning. I did not connect the four o'clock viewing of the primal scene with the four o'clock nightmare. My analysis, by then, had terminated. Therefore I did not have occasion to discuss my mother's account with my analyst.

I have mentioned on several occasions throughout this paper that each incident, as it occurred, was analyzed. In each instance I understood and reached, what we call psychoanalytically, "insights." At all times I considered myself well analyzed to the extent that none of my own problems interfered with analyzing others.

In the fall of 1969, I discussed with a patient of mine the pros and cons of his job change. This man had been employed as a CPA but was offered an opportunity to become the comptroller of an industrial combine. While negotiations were pending, he was asked to investigate the possibility of this combine buying into another industrial complex. My patient was unduly impressed and said, "I always thought that XYZ concern (which he had been asked to join) was big, but against this other combine they are only peanuts." He went on to describe some of the diverse activities which were financed and supervised by this industrial giant.

Suddenly, something clicked in me. It was as if I heard my father speaking. He was a CPA and had been offered a large practice by an elderly colleague of his who was thinking of retiring. A CPA in Germany is held in high esteem because his position affords him intimate knowledge of the inner workings of a business concern or industry. The word "intimate" made me think of sexual connotations. An intimate look into what goes on behind doors, so to speak, in business or industrial board meetings, made me think of what goes on between parents behind closed doors. Why did I connect my father and sex? Since the patient had the last appointment of the evening, I had time afterward for an excursion into my own past.

I started with the first incident—when I had been insulted by the minister, the "Father." I realized that these insults had touched something very sensitive in me. The minister had accused me of not being fit for human company because I had been born of a German mother. Furthermore, the German language is referred to as "the Mother tongue." My murderous rage was prompted by the impulse to defend my mother. It felt as if the minister, this "Father," had taken away from me and degraded my mother. I have commented already on the insight which came with the projected vision of my parents having intercourse while I had to read a paper before a large audience. According to my mother's version, I had found her bed empty on this occasion and begun to cry. I do not recall this consciously but I probably was filled with a murderous rage towards my father because he had taken away my mother. She was not there when I needed her. He was on top of her, obviously degrading and probably injuring or maybe killing her. But even then I repressed my impulses. Something undoubtedly told me that I was

not allowed to be angry towards my father. God was also called "Father." As long as I can remember, the "Our Father who art in heaven," was said by my own father every evening at dinner time.

I had wanted to know what happened between my parents at night. I wanted to know why father acted in such an aggressive manner towards my mother. I was afraid that since he could do this my mother, he could be equally aggressive and perhaps injurious to me. Yet, I could not satisfy my curiosity because it had been repressed and seemed to be nonexistent. As long as I spoke only German (that is, was a child) I was not allowed to be *neugierig* (curious). (This insight, incidently, also explains something else which has nothing to do directly with the topic under discussion—why I matured late sexually and did not have intimate contacts with females until I was nearly twenty-one years of age.)

Why did I have this vision when facing a large audience about to read a paper? I had lectured before to large audiences. I presume that ongoing unconscious processes in my analysis had prepared me for this. Years ago, when the minister insulted me, everybody in the dining room looked at our table. A minister is not usually expected to cause a commotion. He is a man of peace. The doctors and nurses looking at me in the dining room did not know what had happened. For all they knew, it could have been I who had misbehaved and insulted the minister. True, there were no witnesses looking at me when I, as a small child, found my parents in a compromising position. However, I felt guilty. It was as if people knew that I had committed a crime by witnessing my parents' intimacy and wanting to kill my father. Those eight hundred pairs of eyes in the auditorium gazing at me were more than my sense of guilt could tolerate. The appearance, in my mind, of the picture on the wall was like the blowing of a fuse when the wire is overloaded with too much electricity.

Why did I have the nightmare of having to electrocute my father? I cannot answer this with the same assurance I apply to the other situations. I believe that the "murderous" rage which I had experienced towards the minister and undoubtedly years ago towards my own father, was still flowing around in my unconscious. It had not been tamed but was as raw and demanding as it had been when I was still a young child. I do not know why this rage

became conscious when it did. I have only two clues. One is the time element. The nightmare occurred around four o'clock in the morning. That was the hour when I had come into the parental bedroom. The other clue is the mode of killing. Why did I want to kill my father with electricity? A human body twitches when it comes in contact with electricity. A human body, in the throes of an orgasm, also twitches. Over sixty years later, I now completely understand, for the first time, why witnessing the primal scene had evoked such murderous rage.

One question remains: why had I been able to survive as well as I did. Why were partial solutions sufficient? Why had I not become severely and neurotically disturbed over this? I can venture only a guess. I always knew that my mother wanted me, that she loved me, and that she would, if necessary, defend me against real and imagined insults, injuries and rejections. I believe that feelings of great security which I got from my mother, through her very positive feelings towards me, saved me from severe neurotic maladjustments.

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BOOK REVIEWS

THE PSYCHOLOGY OF MELANCHOLY. Mortimer Ostow. New York: Harper and Row, 1970. 140 pp.

In glancing over the title of this volume the reader will note that the author avoids the use of the two terms readily available to psychotherapists; of these terms Dr. Ostow states, "Unhappiness which is pathologically intense is called depression. When depression is severe, it is called melancholia."

The author recognizes depression as a complex condition consisting of different components of psychic pain, anxiety, guilt, worry, and agitation. He states that in most instances the first step in the genesis of depression is the loss of love of some important individual. He also points out that "the patient was originally unable to separate from his mother." Thus, while Ostow is aware of childhood (and adolescent) episodes of depression and sets the highest incidence in the latter half of the fifth and during the sixth decades of the life of the individual, in the opinion of this reviewer it is one of the minor flaws of this study that it does not stress the childhood roots of depression sufficiently and explicitly. This remark is made even in the face of the fact that the author does mention Karl Abraham's suggestion "that clinical depression in adult life repeats an initial and very early childhood depression."

Furthermore, whereas the author does not stress the feeling of loneliness as a potent factor of depression in later life, one may well deduce this from his original definition of depression as originating in the loss of some important individual. Overlooked, it seems, is the anxiety-producing suppressed rage at the person who has abandoned the depressed individual and the latter's fear to give vent to this rage.

While anxiety is mentioned as an essential component of depression, specific fears are not explicitly mentioned. In the opinion of this reviewer, these fears play a significant role; outstanding among these are the fears of self-alienation (using Karen Horney's concept of a shift in a person's energies and consciousness away from his real self), of depersonalization (the state in which a person loses the feeling of his own reality), and finally of gradual deterioration and the culminating terror of death itself.

Another intrinsic cause of depression which is not adequately dealt

with is the feeling of being insignificant and unimportant. A person may sense that he has within himself aptitudes which are not utilized and/or endowments which so far are undiscovered; if these are not being made use of, this condition may well lead to depression. On the other hand, the author points out that it is characteristic of the state of depression that the individual is unable to mobilize his energies and that he is obsessed with an intensified self-observation which is typical of ego function in depression. It is equally characteristic of ego function in depression that the patient is unable to relate adequately to others and thus shows signs of withdrawal and detachment.

Considering the background of the author in both neurology and psychiatry, we are not surprised that he renders a masterful evaluation of the treatment by electric shock and antidepressant drugs. Of the latter, he says they "evidently, do not offer the ideal solution in depression," but does not deny the potential promise they hold.

Psychotherapy is recommended for the clinging of depression stage. This reviewer, however, differs from Ostow's opinion that psychotherapy is not indicated in the state of angry withdrawal; my experience shows that even in this stage the psychotherapist has definite opportunities although there are, of course, definite obstacles to overcome.

The author makes highly significant remarks regarding the tendency of the depressed individual to move toward religious conversion. These remarks wax even more meaningful if by "conversion" one refers not only, as the author does, to the change of religious affiliation, but if one also applies the concept as used by sociologists who apply it to any emotional experience in which the individual comes to feel that he has "found God." Thus the person who has never practiced the tradition of his religious background undergoes "conversion" if he becomes a believing and participating member of his own religious group.

Concerning the final chapter of his book which deals with "Depressive Illness and Social Disorder," Ostow feels that it is "clearly the most disorganized and the least coherent chapter of the book."

The dearth of clinical data and theory may justify this statement. Nevertheless, we are grateful to the author for his effort to draw this eminently important subject into the purview of his treatise. At this time when human existence hangs in the balance, no study of depression would be complete without this most significant topic.

Altogether, we are greatly indebted to Dr. Ostow for his excellent presentation.

HATTIE R. ROSENTHAL

THE MANUFACTURE OF MADNESS: A Comparative Study of the Inquisition and the Mental Health Movement. Thomas S. Szasz. New York: Harper and Row, 1970. xxvii+381 pp.

This book is a passionate indictment against the victimization of so-

called mental patients, especially their involuntary hospitalization, a process which deprives them of their basic rights as human beings and as citizens. The subtitle to the book describes its approach. The author's theme is that the attitude toward the mentally ill is similar to that once taken toward witches. He sees the Mental Health Movement as filling the same role which the Inquisition did in the Middle Ages when it persecuted so-called heretics, chiefly witches and Jews. In both situations the victims served as scapegoats for society and also as objects for the sadistic impulses and power needs of those in control. Both situations expressed the continuing human history of the oppressors against the oppressed.

The author states repeatedly that there is no such entity as mental illness in the sense of a disease of the body. In an earlier volume, *The Myth of Mental Illness,* he explains more fully his view that mental disturbances can better be defined as expressions of problems in living. The purpose of the deviant speech and behavior can be understood as efforts of the person to communicate, both with himself and others. It is a kind of game-playing, a paradigm which Dr. Szasz uses for all behavior in which the disturbed individual seeks to have his needs understood and met but cannot use the conventional means of expressing himself. The appropriate treatment is a dialogue between patient and therapist in a private setting, where the autonomy of the patient is fully respected. The verbal expressions of the patient must be understood by the therapist and translated into the language of everyday life.

The Manufacture of Madness expresses the concept that the state of mental illness is a condition ascribed to certain people by others. Since no such illness actually exists, any more than the state of being a witch existed, madness is manufactured by those utilizing this false label. It is the psychiatrists who manufacture madness by their diagnoses, and a passive, willingly led society which reinforces this system of degrading other human beings. "Society not only shapes the symbolic forms of the madness it creates, but determines the very existence, direction, force, and output of this manufacturing process itself."

One of the problems this reviewer encountered in reading this book was in understanding the nature of the two entities selected for comparison—the Inquisition and the Mental Health Movement. While they share certain aspects in common from a psychosocial, historical viewpoint, as described above, the conceptualization of these movements as similar in the total fashion that this study portrays, carries the analogy beyond the limits of understanding and acceptability. The evils that Dr. Szasz is fighting are embodied in the terms *Institutional Psychiatry* and the *Mental Health Movement* of which it is a part. Both are equated with those forces, authorized by medicine and law, that impose their will on the poor, the sick, and the helpless. The author makes it clear that he is not just fighting against the abuses

found in Institutional Psychiatry. He says, ". . . there are, and can be, no abuses of Institutional Psychiatry, because Institutional Psychiatry is itself an abuse."

Szasz's need to see these institutions in the totally one-sided way that he does, ignoring any positive aspect both in the motivations which created them and the varied tasks they carry on, can only be seen as evident distortion. One gets the impression that the more significant opponent is modern psychiatry as a whole and its historical roots in medicine. His own *Foundations of a Theory of Personal Conduct,* which is the subtitle of the volume *The Myth of Mental Illness,* would remove psychiatry from a medical basis, or even from certain aspects of Freud's psychological orientation, to one primarily concerned with such areas as linguistics, ethics, and sociological forces. Such new theories and concepts have interest and value, but the author's need to demolish in wholesale fashion what he must see as standing in his way is unfortunate.

It would also be unfortunate if the limitations of the volume being reviewed would cause us to underrate the vital message it conveys, that of arousing us more fully to the very real and widespread injustices in our laws and procedures dealing with the mentally ill. Even more significant is the author's analysis of the social forces that have a share in activating and perpetuating the never-ending story of the domination of those in power over the oppressed.

Some of the evils of which Dr. Szasz speaks are not limited to Institutional Psychiatry. Human nature does not change because the setting is a private office rather than a public agency. Perhaps the most serious obstacle to greater success in therapy, regardless of the setting, is that it requires so much of the therapist, not only in terms of his intelligence, training, and skills, but in the quality of his humanity. The percentage of people with this combination of characteristics is not nearly high enough, we must concede.

DOROTHY F. ZELIGS

THE DESIGN WITHIN: Psychoanalytic Approaches to Shakespeare. M. D. Faber. New York: Science House, 1970. 551 pp.

This much needed and long overdue anthology of psychoanalytic essays on the Shakespeare plays is a counterpart to Norman Holland's similarly valuable *Psychoanalysis and Shakespeare.* It provides a generous selection of just those materials which Holland drew upon for both his summary statements of existing psychoanalytic comment on the plays and for his more theoretical pages on the nature of psychoanalytic investigations of the plays. The choice of materials could hardly be bettered. Faber's introduction is brief and to the point. It examines not only the history of psychoanalysis and Shakespeare, but also defines clearly and exactly the purposes of psychoanalytic criticism and dif-

ferences in approach. The introduction, like the book itself, has its connections with Holland's. A point in question is the legitimacy of treating the Shakespeare character as a "real" person. Holland, it seems to me, went to unnecessary and wrong lengths to debunk such treatment—to debunk it in order to exalt other approaches, i.e., treating the entire play as a psychic phenomenon. Faber perhaps has Holland in mind when he argues for the obvious necessity and rightness of the old-fashioned critics, psychoanalytic and otherwise. Even without any overt references to them in the text, Shakespeare's heroines did have girlhoods, and I still think it no mean business on the critic's part to try to reconstruct Shakespeare's intuitive knowledge of those girlhoods.

The book is simply and logically organized: Tragedies, Histories, Comedies. The sonnets and the narrative poems are wisely ignored. For each essay, Faber has supplied a one-page introduction in which he outlines the principal points and, when called for, places them in the pattern of psychoanalytic criticism. The book is aimed first of all at the general critical reader, but its wealth of material makes it necessary for all those with a particular interest in the psychoanalyic approach.

STEPHEN A. REID

THE PSYCHOANALYTIC INTERPRETATION OF HISTORY. Benjamin B. Wolman (Ed.). New York: Basic Books, 1971. x+240 pp.

This volume consists of seven essays, each by a different author and all but one published for the first time, having as their common element the application of psychoanalytic knowledge to the understanding of historical material. The book is cast in two parts, "Interpretations of History" (four essays) and "Biographical Studies" (three essays).

As one would expect, the second part, with its narrower scope, is, on the whole, more successful than the first. Bychowski discusses Joseph Stalin; Lowenberg, Theodore Herzl; and Waite, Adolf Hitler. In each instance the focus is further sharpened by selecting one aspect of the subject for close scrutiny: Stalin's paranoia as it affected his tyranny, Herzl's charismatic qualities, and Hitler's anti-Semitism. The last essay is perhaps the most effective, since it utilizes considerable personal data in a convincing manner to shed new light on the unconscious motivations of overt behavior otherwise inexplicable.

Part I of the book contains a remarkable essay by Waelder which addresses itself to the "Application of Psychoanalysis to Historiography." It is my understanding that this paper is, in fact, the author's last published work, and, in general, it sustains his great reputation. It is not without defects; the author cannot quite lay aside his ideological biases. (It seems a bit strange, for example, to have to refer to Oswald as "the man who, according to available evidence, killed John F. Ken-

nedy.") Yet Waelder does come firmly to grips with some of the principal issues in applying psychoanalysis to the study of history. His discussion of three problems of history—the selection of relevant facts, the determination of "what actually happened, externally speaking," and the interpretation of human behavior in terms of human nature—is lucid, and his demonstration of the usefulness of psychoanalytic knowledge in the solution of all three problems is convincing.

The other essays in this section, while there is interesting reading in all of them, come off less well: Lifton's on "Protean Man," Grimsley's on the history of psychoanalytic literary criticism, and Wolman's on "Sense and Nonsense in History." Lifton's paper is an important statement but it could have been written by a scholar far less well acquainted with psychoanalysis than its author. Grimsley's is sharply focussed, but criticism of criticism is a rather thin soup. Wolman's paper contains felicitous passages but lacks consistency.

In thinking of the book as a whole, one comes back to a statement by Waelder. "After three-fourths of a century," says Waelder candidly in the book's first essay, "the actual results of psychoanalytic study of history are disappointing." This being the case, it is difficult to see how a book devoted to this subject could have avoided being somewhat disappointing also, and Wolman's book does not entirely avoid this verdict. Yet the book clearly demonstrates that there is enough promise in the application of psychoanalysis to the field of history for the effort to be encouraged. For this demonstration, the editor and authors deserve credit.

CHARLES K. HOFLING

PSI AND PSYCHOANALYSIS: STUDIES IN THE PSYCHOANALYSIS OF PSI-CONDITIONED BEHAVIOR. Jule Eisenbud. New York: Grune & Stratton, 1970. 359 pp.

If *Psi and Psychoanalysis* has induced as much procrastination in other reviewers as it has in this writer, its significance as a vitally important text for practicing psychoanalysts will come as a belated surprise to many professionals who by now should have read the book itself.

The operational analysis of psi (paranormal communication) in treatment, however, necessitates the presentation of such a vast network of circumstantial detail as to demand closest attention on the part of the reader. In consequence, the present report has only materialized by virtue of this reviewer's weekend retreat to land's end. Since we are, after all, speaking of psi, and for what it's worth, the assignment was also set aside abruptly some months ago for no better reason than blind obedience to an irrational, uneasy compulsion to review a different volume of no priority whatsoever. A humane decision, as it turned out, for shortly thereafter its author, residing in England and reportedly in excellent health, died suddenly—but not without having had the pleasure of receiving a carbon copy of my favorable reaction

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————. *Therapeutic Communications with Children: The Mutual Story-Telling Technique.* New York: Science House, 1971. 969 pp.

GATES, DONALD EDSON. *Elmer Gates and the Art of Mind-Using.* New York: Exposition Press, 1971. xi+540 pp.

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HALLECK, SEYMOUR L. *The Politics of Therapy.* New York: Science House, 1971. 283 pp.

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HEINE, RALPH W. *Psychotherapy.* Englewood Cliffs, N.J.: Prentice-Hall, 1971. x+170 pp.

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HOMME, LLOYD. *How to Use Contingency Contracting in the Classroom.* Chicago, Ill.: Research Press, 1969. xi+130 pp. (Paperback).

HUNT, WILLIAM A. (Ed.). *Learning Mechanisms in Smoking.* Chicago, Ill.: Aldine, 1970. 237 pp.

JACOBS, JERRY. *Adolescent Suicide.* New York: Wiley & Sons, 1971. xi+147 pp.

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JARDIM, ANNE. *The First Henry Ford.* Cambridge, Mass.: MIT Press, 1970. ix+278 pp.

JOHNSON, BRUCE. *Conrad's Models of Mind.* Minneapolis, Minn.: University of Minnesota Press, 1971. vii+231 pp.

JONES, ERNEST. *On the Nightmare.* New York: Liveright, 1971. 374 pp. (Paperback).

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KARLEN, ARNO. *Sexuality and Homosexuality: A New View.* New York: Norton, 1971. xx+666 pp.

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LANDIS, BERNARD, and EDWARD S. TAUBER (Eds.). *In the Name of Life: Essays in Honor of Erich Fromm.* New York: Holt, Rinehart & Winston, 1971. xiv+333 pp.

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MAHLER, MARGARET S. *On Human Symbosis and the Vicissitudes of Individuation. Volume 1: Infantile Psychosis.* New York: International Universities Press, 1970. xi+271 pp.

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MCDONALD, MARJORIE. *Not by the Color of Their Skin.* New York: International Universities Press, 1970. xi+242 pp.

MENDEL, WERNER, M. *A Celebration of Laughter.* Los Angeles, Calif.: Mara Books, 1970. 189 pp.

MENOLASCINO, FRANK J. (Ed.). *Psychiatric Approaches to Mental Retardation.* New York: Basic Books, 1970. xx+764 pp.

to his book which—again impulsively—had been mailed posthaste to him upon completion. May the skeptic take heed!

Returning to the main issue, let it first be established that the clinical data reported in *Psi and Psychoanalysis* constitute only selected examples from an extensive research carried on by Dr. Eisenbud since the early Forties. Of the handful of analysts who pursue the study of psi in their practice, it is safe to venture that none have documented these phenomena, including their relevant analytic associations and antecedent determinants, as assiduously as this author. To do so is not only a voluminous task but a relatively thankless one. To seek to prove, as the author does, that the occurrence of psi in the analytic situation represents a complex transference-countertransference manifestation is to invite attack from two sources; from experimental formalists in parapsychology proper, for the nonquantifiable nature of the phenomena involved, and from conservative analytic circles—for the implicit threat posed by psi against two cardinal assumptions in psychoanalytic procedure: first, the presumptive power of "the word" as opposed to nonverbal means of communication; second, the belief (upon which transference-projection analysis depends) that the analysand's access to information about the analyst's private life and his mental processes depends entirely upon what the analyst reveals or what is revealed about him by others.

Between this Scylla and Charybdis Dr. Eisenbud steers his central thesis: that psi erupts through a concatenation of similar, or complementary, psychic material breaking through in temporal correspondence between patient(s) and analyst, and that the analyst's (unconscious or preconscious) countertransference activates the critical linkage between the dovetailing psi productions of his patients. It is precisely this involvement, says the author, which "sets historical situations such as we are dealing with apart from those in which psi is not a factor to be considered." He continues:

> It has become more and more apparent that our only workable yardstick is the observer himself who . . . is from first to last inseparably a part of the very situation he is observing. By way of accounting for the correspondences he establishes and elects to investigate, the observer finds that he has to grub around in and with his own mental operations, and that if he wishes to introduce meaning and order into the raw and formless situation he cannot look to much help from independent measures of values or significance. On top of everything he now discovers that in the process of doing this he himself emerges from the shadows of the very object of his investigation, and that object and subject fuse as he finds himself peering into an imperfect and somewhat smudged mirror which itself merges into an indefinite background. (p. 135)

This thesis is supported by thoroughly documented case material tracing the connections between psi correspondences in his patients with

hitherto dormant conflicts involving oral, Oedipal and genital events in the author's history, as well as sibling rivalry and its later derivatives.

To pinion his clinical data in broader context, the first section of the work reviews certain methodological problems encountered in all psi research: the use and misuse of probability theory, defining the differences between "open" and "closed" correspondences, and criteria for application of the psi hypothesis—"psi" meaning, as the author points out, "nothing more nor less than the question mark remaining after all so-called normal alternatives have been excluded." These orientation chapters are liberally illuminated with typical examples from Dr. Eisenbud's practice as well as citations from and references to the general literature of parapsychology.

Beside coming to understand psi phenomena in therapy comparatively through the relentless process of self-examination which he designates as "triangulation," years of experience have alerted the author to certain clues regarding the emergence of psi, such as dreams which employ the theme of looking or spying; references to objects in dreams which employ the principle of looking, such as cameras, telescopes, lenses; appliances used in communication such as telephones, radios, TV's; or dreams which negate the use of any overt means of communication, where the dreamer "knows" what is meant without being told.

The author's striking formulations and capacity to sustain the reader's attention through a maze of interlocking data where a more pedestrian writer would fail tempts this reviewer to summarize a case, but to do so without reference to the critical associative data would negate the scholarly intent of the book. I will therefore limit myself to brief mention of its closing chapters. In one, Dr. Eisenbud discusses his handling of psi material with patients. He says:

> In the handling of conceivably psi-conditioned correspondences between the dreams or other material of different patients, or between my own material and that of patients, I have tried generally to proceed on the principle that the actual mechanics of interpretative cross-fertilization be guided primarily by the overall requirements of the analytic situation, with all other considerations subordinated to the clinical value of a given step. . . . There is little point in demonstrating psi for psi's sake. (p. 321)

The final chapter of this courageous work deals with larger epistemological issues raised by psi and possible avenues for its further exploration. Meanwhile, those of us whose scientific endeavors are bounded by the walls of our consulting rooms will contribute our share to psi and psychoanalysis by reporting the results of both our patient's self-examination and our own when we encounter this fascinating phenomenon.

MARIE COLEMAN NELSON

THE THEORY AND PRACTICE OF MENTAL HEALTH CONSULTATION. Gerald Caplan. New York: Basic Books, Inc., 1970. xiii+397 pp.

Dr. Gerald Caplan is Professor of Psychiatry and Director of the Laboratory of Community Psychiatry at Harvard Medical School. He has edited *Emotional Problems in Early Childhood, Prevention of Mental Disorders in Children,* and *Adolescence: Psychosocial Perspectives.* He has written *Principles of Preventive Psychiatry,* the first volume in the trilogy of which the volume under review is the second offering. The third in the series will be concerned with problems of community practice in the mental health field. If it is the contribution that its predecessors have been, we most eagerly await it.

Perhaps it is a mark of the extent of the contribution that Caplan himself here has issued a caveat. In the Preface, he tells us that this book is "uneven in quality," incomplete, and only "intended as a general guide." It is, however, the latter warning that we must really hear so that we will remain flexible and open. While the book is indeed uneven, it is not seriously so.

Caplan also notes that this major model of consultation, as with Lindemann's approach with which it was later linked, was not "a result of planning based on theory." Well, perhaps not explicitly, but certainly both have been well grounded in psychoanalytic sophistication and insights—as seen, for example, in the influence on their work of loss theory—and also extensive experience. We maintain that this is true despite such relatively slight lapses as ". . . customary procedure in analytic psychotherapy in which, unless one is treating a patient with a very fragile ego, the therapist tries to maintain as high a level of emotional tension as possible. The purpose of this in psychotherapy is to force unconscious material to the surface . . ." (p. 203). We also question Caplan when, to aid in dissipating distorted institution-based expectations, he advises that the entering consultant ". . . should allow the staff full freedom to manipulate him . . ." (p. 56). Surely this must be seen, for example, as poor training for that institution's consultees and those other staff who significantly interact with and influence them, and hence self-defeating.

Throughout most of the volume Caplan defines his terms, and gives us his thoughts on developing a consultation program in a community and on building the relationship with both the consultee institution and the consultee. The chapters are built in a clear and coherent fashion around Caplan's four basic subtypes: client-centered and consultee-centered case consultation, and program-centered and consultee-centered administrative consultation. Techniques of theme interference reduction are also treated in a separate chapter.

Caplan also writes on the need for evaluation in this area, and some of the problems encountered—particularly as illustrated in the 1959-1964 evaluation effort in which he was involved. This chapter ends with a plea for "frankly exploratory" evaluative studies in con-

sultation—aiming at, in part, "improvement of our evaluation technology." Still, do we have to be all this exploratory if we pay heed to Fiske, Bergin, Strupp, Schuldt, Truax and others who have provided us with evaluative insights from psychotherapy research, to Barry as he writes in *Professional Psychology* (Vol. 1, 1970, pp. 363-366) on criteria in consultation evaluation, and to AIR's recent *Evaluative Research: Strategies and Methods,* as well as to the classic of Webb and his associates? Research in the drug-abuse area today, in the main, parallels the state of alcoholism research twenty or so years ago. Evaluative researchers in mental health consultation can avoid following a wasteful road by learning from similar research in another helping (or care-giving) relationship—psychotherapy. We can learn through coordinate communication, cooperative collaboration, and good consultation.

Caplan also describes the Laboratory of Community Psychiatry's training program, and in his last chapter, reveals how much further along his thinking is from an illness model than is that of Yolles, who has written the foreword. Thus, Caplan truly strives toward his ultimate goal of primary prevention, and here, in *Theory and Practice,* has immensely aided us in this task.

ERNEST W. FERNEAU, JR.

THE MIRAGES OF MARRIAGE. William J. Lederer and Don D. Jackson. New York: W. W. Norton, 1968. 473 pp.

Numerous books appear in print each year, dealing with many aspects of marriage counseling. The fact that so many books concern themselves with marriage indicates that a dire need exists for the understanding, clarifying and realigning of marriages. It is difficult, if not confusing, to select and read that book which will answer most questions posed in this area. The volume under review is such a book.

Instead of perpetuating time honored clichés, the authors point out that one of the underlying causes for the ever-growing rate of marriage failure lies in the fact that "American thinking patterns and traditional American values concerning marriage are rusty, broken down, obsolete." They also call attention to the fact that our current laws concerning marriage, divorce, alimony and custody were taken over from English common law—some over five hundred years old.

The authors concentrate on four goals. Through comparisons and pertinent case discussions they show the reader how the maladies of modern marriage can be diagnosed. This helps the reader to diagnose his own marital situation. It tells how outside diagnostic help can be secured when a couple cannot identify their own marital ailment. The book suggests ways and means through which a sick marriage can be nursed back to health. Finally, if a marriage is dead, one should recognize "that it is a corpse so that it can be buried with grace and

maturity and to do so within the framework of current laws and religious beliefs."

The authors attack such mirages as "people marry because they love each other," "love is necessary for a satisfactory marriage," "the advent of children automatically improves a potentially difficult marriage," "loneliness will be cured by marriage," and that "if you can tell your wife to go to hell you have a poor marriage." Marriage is disected and looked at as a pathologist looks at human anatomy. There is a discussion of different types of marriages, such as the stable-satisfactory, unstable-satisfactory, unstable-unsatisfactory, and the stable-unsatisfactory. Destructive elements in marriage are discussed in a manner somewhat reminiscent of Berne's *Games People Play.* With tact, insight, and clinical acumen the authors show how, consciously or unconsciously, two people who originally accepted each other for better or for worse hack away and undermine the foundations of their marriage. Several techniques are enumerated "to drive your spouse crazy."

The authors then present their viewpoint of ways and means to make a marriage work. To achieve this end, communications have to be established. Quarrels and aggressions, these inevitable ingredients of every marriage, are analysed in terms of their "true" meanings. A successful marriage depends on compromise, which the authors call "quid pro quo" (something for something). This is not the same as "tit for tat," but it enables both partners to know they are peers, and in this way dignity and self-esteem are preserved.

There is a brief section on securing professional help, and a suggested reading list on marriage and family living, and the California requirements for professionals who work with marriage problems are appended.

The book is well written and free of professional jargon and long-winded philosophical speculation. Most of the chapters are brief, some covering only three or four pages. The print is pleasing to the eye and facilitates easy reading.

It must be sadly stated that Don Jackson did not see this volume as a finished product. He died suddenly at the age of 48, while the book was in proof. Anyone reading *Mirages of Marriage* will agree with Dr. Karl Menninger's tribute to Dr. Jackson (in the Foreword): ". . . cut off mid-course in a brilliant career of research and education. We miss him for his great personal charm, his earnestness, his devotion to people, and his place in psychiatry."

This reviewer has seldom read a book that gives so much within a space of less than 500 pages. He hopes that not only professionals working with marriage problems, but also married people themselves will read this book. *Mirages of Marriage* should become for marital counseling what Spock's book has been for baby and child care.

ADOLF G. WOLTMANN

LOVE AND WILL. Rollo May. New York: W. W. Norton, 1969. 352 pp.

In *Love and Will* we are treated to the thoughts and observations of a four-part man—May the psychologist, May the existentialist, May the theologian, and May the human being who is interested in seeking truths and in understanding what is going wrong in our present society.

The author's approach is one which sustains the interest of the reader by frequently shifting from his case work in analytic practice to observations on the larger problems that are confronting man today, and by calling upon a variety of disciplines—mythology, religion, biology, and philosophy—to accomplish his task.

May believes that our neurotic patients experience more fully than other people and therefore serve as accurate barometers of their time and place. They "are the ones who express and live out the subconscious and unconscious tendencies in the culture" and "predict the culture by living out consciously what the masses of people are able to keep unconscious for the time being." May, therefore, uses his patient interviews amply and sensitively to gain insight into the phenomena of our time.

He contends that the shift in his private practice has been, over the years, from the patient who came in because of feelings of anxiety and guilt about sex in the 1940's to the patient in the 1950's whose problem was one of identity, to the patient of the present day who comes in complaining of a lack of feeling and passion. May believes that in our attempt to emancipate ourselves from puritanical and Victorian repressive influences, we have become a society that is more concerned with the mechanical performance of the sexual act, for example, than with actual enjoyment of sex, or with feelings of intimacy, love, and just being close that may accompany the sexual act.

As a concomitant of our emphasis upon performance, May contends, we are increasingly becoming a nation of schizoid individuals, individuals who overly intellectualize, who view emotions as reactions that can be evoked mechanically, and who, in the process, find themselves increasingly tending towards feelings of emptiness, of being forlorn and in a state of apathy. From apathy, we turn in desperation to whatever may bring us a sense of feeling and being alive. One outgrowth of this, according to May, is violence. He firmly believes that "there is in our society a definite trend toward a state of affectionlessness as an attitude toward life, a character state."

May makes very cogent observations when he reflects that hate is not the opposite of love, but rather it is apathy, and that the opposite of will is not indecision but rather uninvolvement and detachment.

I have found in my extensive work with teenagers who are drug addicts that for many of them sex has become a mechanical act at best, and that many others are quite uninvolved with sex and are unconcerned about it altogether. They seem more interested in talking

about drugs and their habit and are much more concerned with the pleasurable feelings that are evoked as a consequence of drug-taking than with feelings of intimacy or love that sex can bring.

May continues his journey by commenting that for many in our society the four-letter word *love* has become a dirtier word than the word *fuck*. He believes that Freud attempted to get along without Eros in his own theory but found that if he were seeking to account for civilization and its discontents, Eros had to be looked at and expanded in its conceptualization. For May, Eros is much more complicated than the singular concept of libido.

A further major point that May makes is in the area of will and self-determination. His definition of will is "the capacity to organize one's self so that movement in a certain direction or toward a certain goal may take place." He seeks to resurrect the concept of will from philosophy, polish it and reintroduce it into psychological thinking. I believe that psychology can benefit from attempting to come to grips with what will is, how it functions, and in what manner it serves to permit the human being to be consciously in charge of his environment, rather than to let the powerful and overpowering forces take charge of him.

There are some highly interesting sections in Love and Will on the demonic, which May traces through mythology, and its uses in religion, literature, and the classics. He writes of both the creative and the destructive properties of the demonic in all of us, and warns that if left ignored, the destructive elements in it may get out of hand, in the direction of either the violent act or psychotic behavior.

In summary, Rollo May has a gift for synthesizing various disparate elements of his perceptual world and making some sense out of them. His book is well worth reading, not only for some of the answers he presents, but also for the many questions he raises. For the professional reader, there are clarifications of concepts that have been associated with May in the past, such as existentialism and anxiety. His presentation of the schizoid man is of real value. I would have liked to see a much more intensive development of the treatment of the schizoid man, but perhaps psychotherapy did not come within the scope of this book. However, if May's conjectures about the kind of man we are creating are true, his book may become an important landmark in our awakening to the potentially frightening realities of what future man will be like and how we today in our 1972 society are going about shaping him.

HERBERT J. FREUDENBERGER

THE HANDS OF THE LIVING GOD. An Account of a Psycho-analytic Treatment. Marion Milner. New York: International Universities Press, 1969. xxxi+444 pp.

The author, an English psychoanalyst, became well known in 1950 when

she published *On Not Being Able to Paint*. She selected the title of the present book from a 1920 poem by D. H. Lawrence, titled "Pansies." "It is a fearful thing to fall into the hands of the living God. But it is a much more fearful thing to fall out of them."

This book details the psychoanalytic treatment of a single patient, Susan, who spontaneously discovered her capacity to doodle. At the start of treatment Susan was very schizoid. Her ability to doodle filled in where the spoken word failed. Doodling led to drawings which reveal the deep unconscious perception about the nature of the battle between sanity and madness. These doodles and drawings (of which over 150 are reproduced in this book) together with Mrs. Milner's sensitive description of the therapeutic sessions constitute the revealing, unique and compelling interest of this book.

Treatment started when Susan was 23 years old and had just been released from a hospital where she had received electro-shock treatment. She told Mrs. Milner, three weeks after the last shock treatment, that she had no feelings and that nothing mattered. The treatment period lasted for twenty years, during which time Susan slowly found her way back to reality and eventually got married.

Art has been used in the treatment and psychotherapy of mentally ill persons before, but this is the first long-range project where this type of graphic communication has been skillfully used to supplement oral psychoanalysis. Mrs. Milner admirably succeeded in her therapeutic goals.

This reviewer assumes that Mrs. Milner wanted to present primarily the treatment process, because neither in the text nor in the bibliography does she mention similar work done by Margaret Naumburg in this country and by Ainsley Meares in Australia. These omissions do not detract from the content of this book, which is highly recommended to all professionals using art as an aid in psychoanalytic treatment.

A.G.W.

I'M OK—YOU'RE OK. Thomas A. Harris. New York: Harper and Row, 1967.

The basic scientific unit of Transactional Analysis is the transaction, defined as follows:

> The unit of social intercourse is called a transaction. If two or more people encounter each other . . . sooner or later one of them will speak, or give some other indication of acknowledging the presence of the others. This is called the *transactional stimulus*. Another person will then say or do something which is in some way related to the stimulus, and that is called the *transactional response*.

Attention is on the transaction rather than on past history or character structure per se. Language used is not id, ego and superego but "child," "adult" and "parent."

I found Harris' presentation valuable, both personally and professionally, and I expect it has value quite generally, whether the reader is a psychotherapist or not and whether the psychotherapist has identified himself with a "school" or not.

I do have some misgivings. I wonder if it is wise to teach patients a "system" and a nomenclature. I wonder what it means that Dr. Harris casually approves of drugs and electro-shock therapy (page 111). I am not quite comfortable with the statement that a healthy person is a dispassionate one. I am uneasy about leaving feelings identified but not any further worked through (I think of cancer and heart trouble and other things).

I have the impression that Transactional Analysis is going to grow and thrive and improve. Finally, I would like to say that Dr. Harris writes not only well and meaningfully but that he has delightful ways of putting things.

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